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Clinical Handbook of Transcultural Infant Mental Health

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In memory of Dr. Klaus Minde and Dr. Gonzalo Manzano-Zayas, generous and inspiring mentors
To Abel Jiménez and Dalila Neira
For always nurturing a pichón
To my family and friends. To my teachers and mentors and especially to my parents

Foreword

A defining feature of today's world is the trend toward increasing globalization and the reactions—both accepting and rejecting—brought about by such tendency toward cultural homogenization and intensified economic and social relations between nations. The power of technology, such as a global social media giving immediate access to most people in the world to events and ideas occurring anywhere else in the planet, joins forces with the greater contact between people brought about by travel and commerce across international boundaries.

In the industrialized countries, in particular, immigration—both legal and illegal—and a surge of refugees escaping poverty and violence have intensified the pressure to create communities where different cultures, customs, religions, dresses, cuisines, and ethnicities can coexist in harmony. A counterreaction to such multiculturalism appears to be sweeping industrialized countries, where many members of the local, dominant culture and ethnicity feel threatened by the potential "loss" of their culture and social or ethnic identity spawning, in turn, a resurgence of nationalism and xenophobia, fear and hostility of the "other," and suspicion of those in their own culture who have "betrayed" it by aligning themselves with the "other" and welcome multiculturalism and globalization and accept and even appreciate diversity.

This dialectical process between globalization and multiculturalism, on the one hand, and ethnocentricity, nationalism, and rejection of diversity, on the other hand, is likely to shape this signal struggle of the new century. It is a process that provides a context that heightens this book's pertinence and relevance.

This impressive compilation of chapters ranges from the earliest phases of human development—the perinatal phase and early childhood—to efforts to illuminate how the contact with "the other," while capable of generating defensiveness and prejudice, can also promote a deeper understanding of ourselves. This is not a collection that highlights the "quaint" and esoteric practices of others as much as an exploration of the universality of human needs, aspirations, and hopes that all families harbor for their children, as embodiment of the future, and as these universal themes are differently expressed in particular cultures.

Both the editors and the authors are first and foremost practical, committed clinicians, who combine clinical knowledge and wisdom with sensitivity and compassion. Offering glimpses of how these clinicians' approach and work with patients and families of diverse background makes this book

particularly useful and relevant for all disciplines involved in providing social services, health and mental health services, and early childhood interventions to children and families. It does so by embodying a mentalizing perspective, a view that seeks to "see the other from the inside and oneself from the outside" and thus not only affords a meaningful understanding of the other's point of view but also promotes a timely questioning of ideas and practices all too often taken for granted.

This book's first section examines how culture becomes embedded and embodied in children's bodies and minds as the early attachment relationships provide a context that signals to children to trust, internalize, and believe in the universality, applicability, and validity of ways of thinking, speaking, feeling, preferring, acting, and interacting, transmitting from one generation to the next parents values, attitudes, expectations, and prejudices. In so doing, this section offers an invitation to all readers to examine their own unavoidable biases, both conscious and unconscious, regarding others and our judgments of what is "good," "normal," "healthy," or "desirable."

This book's second section reviews how clinicians deeply knowledgeable about children and families of various backgrounds connect and work effectively with them. Particularly useful is the careful balance each of these chapters achieves between, on the one hand, highlighting common themes in families from a particular background, such as Latino or Native American, and, on the other hand, emphasizing the enormous diversity within these groups and the necessity to ultimately appreciate the uniqueness of each child and family. One of the chapters examines, from an "outsider" perspective, the views and particularities of European–American children and families.

The chapter on Asian children and families heavily focuses on Japanese families, illustrating issues of interdependency and the impact of a strong cultural emphasis on accommodating to the group, as in the common refrain that "the nail that sticks out gets hammered." The chapter focusing on Latino families emphasizes the vicissitudes and challenges faced by migrants, particularly undocumented ones, seeking to find a safer, better life in the United States for them and their children.

The third section of this book examines children's problems affecting families of all backgrounds, including sleep problems, feeding problems, crying, discipline, and limit-setting, and reactions to children's health issues and problems. Each of the chapters in this section takes on a particular problem, discussing how families of different backgrounds experience, approach, and seek to resolve these common issues. One of the chapters describes one country's efforts to create a national program designed to promote secure attachment in the population at large, out of the conviction that secure attachment is, in turn, a "salutogenic," protective factor that would enhance health, mental health, and resilience in the next generation.

The fourth and final section explores the "healthy immigrant effect," countering the notion that acculturation to the dominant culture provides the greatest advantages to immigrant children and families. The chapters in this section by contrast look at the evidence of the protective and resilience-promoting impact derived by families of embracing their new culture while also retaining an adherence to their own traditions and cultural wisdom and values. The final

chapters in this section discuss traditional healing practices, particularly those pertinent to the perinatal and early childhood periods. These practices, widely utilized throughout the world, seem to have undergone a resurgence of interest in the industrialized world, where approaches such as herbal medicine, ayurvedic medicine, and other practices are seen by many as complementary or alternative approaches to the medicalization of life's problems.

In sum and in conclusion, all clinicians working with children and families will find in this book a fascinating, timely, and eminently practical reference that will offer better understanding and useful tools to approach and work more effectively with children and families of diverse backgrounds.

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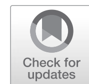
Part I

Conceptual and Background Issues



1 What Are Cultures and a Cultural Frame of Mind in Clinical Interventions

J. Martin Maldonado-Duran and Clara Aisenstein

What Is Culture

The Universality of a Cultural Frame of Mind

Culture is a complex concept. It involves thought, theorizing, and a way of perceiving, of making sense of the world, and of understanding what happens around us. Culture also comprehends the way a person or a group respond and behave in view of those thoughts, perceptions, and feelings. Culture is also a framework to move and act according to certain principles (Mauss 2007) that are more or less accepted within a particular group of people with similar beliefs and perceptions. An extremely wide definition, but true, is offered by Hufford (1990) suggesting that culture is the non-biological inheritance of human beings.

Culture determines the body and the mind. It also influences relationships, family, and group structure and functioning and ways of interacting between individuals (Maas 2009). It can be said that culture is a part of the "ideological and behavioral superstructure" that is passed on from one generation to another through family interactions, schools, communication, media, and everyday life experiences. According to several theoreticians, it is a way of seeing the world, of thinking, and of wanting things that one should see, think, and want. The social order is thus preserved, and people "stay in their place" more or less thinking and doing what they are expected to do.

Defining culture is difficult and hazardous. Also, writing a book about "cultural practices" is challenging because of the diversity of cultures and the danger of generalizations, stereotyping and unfairness. What one may consider "African-American culture" may be in reality many different beliefs and practices, with only some commonalities.

The practical application of a specific culture is that people develop a belief system, a guide to conduct their lives, to raise their children and to solve problems without necessarily having to think about every opinion or decision de novo. One could say it is an implicit and unconscious set of assumptions and practices that guide everyday life without having to stop and think at every turn. People grow up in a certain culture or cultures and develop their "own culture," so to speak, which they likely transmit to the next generation.

Cultures evolve and change, and at the same time, there are forces that attempt to keep the culture stable, to remain relevant, and to preserve

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itself. Parents foster the development of certain "traits,' beliefs, behaviors, and goals for their children, which are generally concordant with their culture. A way to preserve a certain cultural framework is the techniques of child-rearing and the adherence to certain behaviors and beliefs that are supported by a given ideology. This ideology is embraced by the large social system and is also transmitted and reinforced through education, mass communication media, laws, religious beliefs, and moral aspirations of a social group (Allison 2015).

It would be impossible to generalize anything about the culture of a social group, because every individual is indeed unique and has his or her own set of beliefs, practices, ways of seeing the world, raising children, and promoting their well-being. Also, although there may be some or even many commonalities, in the "real world" and certainly in the clinical setting, each family is unique.

At the same time, it may be useful for clinicians and researchers to reflect on the nature of various cultural groups. There will be a multitude of cultural practices that clinicians will encounter in places such as a hospital, a clinic, a school, and other institutions. For instance, a given clinician, physician, and mental health professional will encounter individuals and families who identify themselves as "Latino" or "African-American" in a health care system, home visitation program, child care center, obstetric service, newborn nursery, etc. It would seem important to understand something about their world view, what is important to them, how they expect to be treated, what they consider valuable, and what might be offensive or forbidden.

Our purpose in this chapter is to offer some suggestions on how to recognize and value different cultural practices and to take them into account when evaluating an individual or a family and seeing their difficulties within that broader context of "their culture." This will give clues on how to deal with them and on how to approach persons of a "different culture." At the same time, we hope to alert the clinician to the fact that his or her own background is also part of a set of beliefs and practices that are "his" or "her" culture. The awareness of the fact that one also has cultural beliefs and values might help question the belief in "absolutes" and certainties about what is good for children and how they "should" be raised. Looking at different points of view may help one understand the other and also question one's own assumptions about what is correct, how things "should be," and what is good and desirable.

Animals and Culture

Jane Goodall and after her many other researchers working with various animal species have described the fact that animals such as chimpanzees, gorillas, and many other primates (McGrew 2004), but also crows, other birds, and many other animals, "learn" from their group certain practices to achieve goals. Such practices might be different from other groups, even neighbors, or "tribes," of the same species to use a different approach to reach the same goal. DeWaal (1999) described groups of Japanese macaques that learned to wash sweet potatoes before eating them. They would wash them on a body of water, like a lake or a river. When the youngsters and neighbors see this approach, they imitate it, and the practice then becomes generalized. This is not observed in other groups of Japanese macaques that are situated elsewhere and haven not seen the practice. Something similar has been described regarding a sort of "exchange system" for grooming in other primates. Grooming is a caregiving behavior that can be compensated with food and payment, so to speak, with different values depending on the duration of the grooming. The payment for grooming a female with an infant might be that the mother might allow the groomer to hold her infant for a determined period of time, depending on the length of the grooming, as has been observed in a group of *Macaca fascicularis* (Gumert 2007). Other members of the same tribe may adopt a similar exchange system of compensating for grooming which they observe in the dominant members or elders.

Some capuchin monkeys in Venezuela have learned to rub themselves with a certain plant

(containing benzoquinones) during the day apparently in order to repel mosquitoes and their stinging during the evenings (Weldon et al. 2003). The technique of "applying the repellent" has been transmitted from one Capuchin monkey to another observer and learned in this way, so it is generalized in some groups.

This imitation and adoption of practices have been observed also with making tools. In some groups of chimpanzees, in order to catch termites, a thin stick is introduced in a termite mound. In order to open nuts, stones or other heavy objects may be used. Hunting in groups seems to be another tradition learned within the group among troupes of chimpanzees (Boesh 2005), in which they develop a certain group strategy to achieve their objective.

The youngsters are "trained" by their parents in the best techniques that have been developed in that particular group and can be described as cultural practices (Perry 2006). More is learned everyday about how adults teach youngsters strategies to hunt and to solve problems, and we are only at the beginning of a fuller description of these phenomena (Geissman 2003). In ethology and primatology, researchers often talk about "traditions" to describe those learned strategies of problem-solving. Something similar can be seen among families of crows and other birds.

Culture and Biological Predispositions

Aside from culture, human interactions are also influenced by biological predispositions for instance between a mother and her baby, father and infant, and in many other human interactions. There are strong biological tendencies, such as the sucking reflex in the newborn, the need to cling to an attachment figure later on in the first year of life, and seeking that figure for protection, as well as the need to explore. However, how specific tasks are achieved by humans, such as obtaining food, sleeping arrangements, achieving a minimum of safety, playing, and others, are also influenced by culture in an interplay with biological predispositions. Different human groups will develop varying strategies to promote certain behaviors and discourage others. It is important for the clinician to understand the purpose of practices that may appear harsh, puzzling, or overindulgent, when viewed outside of their social context. This will make it possible to get a better perspective of what the clinician is observing and what is the value or meaning of a specified behavior or practice for the family and society as a whole.

Everyone Has Culture(s)

In days gone by, a person was exposed to one culture of origin, and that was considered the roots of who the person was. Parents and other relatives, mentors, teachers, and religious figures imparted a set of assumptions, beliefs, practices, and ways of being in the world that were thought to be useful for the person who inherited them and in turn transmitted them to the next generation. Perhaps most individuals would accept these assumptions and practices unconsciously and as "the way the world is." Like fish in the water, most of us might accept what we learned from our social group as "the way things are" or "the way things ought to be" or "the best way". We adopted beliefs and practices in everyday life, most of them without question. Of course, in adolescence many individuals would question certain assumptions and adopt new beliefs or practices perhaps as a way to separate emotionally from their parents and develop a "new identity."

Despite this questioning, one still inherits cultural practices about how, when, and what to eat, where and when to sleep, and with whom and at what time to go to sleep and wake up. The way of taking care of babies might still be passed from one generation to another – in much of the world – without questioning every aspect of the thousands of details what are involved in looking after a baby, promoting his or her growth and development. These "ways of doing" and belief systems are what we intend to describe in the various chapters. Increasingly, with globalization and new communications, people might be

exposed to “different ways” from other cultures and desire to embrace them or reject them, but there may be many “mixtures of cultures” compared with how the world was even 50 years ago.

In describing what “a cultural group” does or believes, there is a danger of offending them, including professionals of any cultural background, because one is describing generalizations and making assumptions. From the start, one has to emphasize the need to look at every person and family as unique and different from others, even if they belong to a certain “cultural or social group.” In the clinical setting and in an intervention involving people, it is important to reflect on the uniqueness of each person, family, and situation. One should not assume that because of a family is “African-American,” one already knows a lot about such family and about their beliefs and practices. On the other hand, if there are certain themes and traditional beliefs which would help the clinician or institution understand and see the world from the point of view of the family that is “different”. In that scenario their way of dealing with their children, their parental beliefs, and their values might not just be considered odd or alien to ours, but would make sense if one were to see the world from their perspective, their history, including a transgenerational history.

Whenever possible the clinician can resort to the available scientific literature in order to better understand a cultural group, realizing that nothing can necessarily apply to a “particular family” or even a “particular group” no matter what their cultural background is.

There is ample variation in practices and beliefs even within a cultural group or a country. If one were to say “the culture in the United States,”, immediately the question arises as to what that means. There are multiple groups, very different, even if they descend from European immigrants. The descendants of Greek immigrants might have different practices than families whose origin is from Germany or Sweden. Also, the “cultures” are different in the South, the Northwest, or the Northeast of the country. The same can be said of India, China, Mexico, and most countries. They are not uniform blocks in which everybody is the same and has the similar beliefs and cultural practices.

Rather than attempting to describe phenomena in the “real world,” concretely and in every possible case, we wish to “illustrate” points by describing different practices and exploring their possible origin, their survival value, and how they might be useful to perpetuate a particular culture and way of subsistence which would be transferred to the next generation. From the concrete examples, one could try to generalize to “principles” or ideas that help understand why a particular family might be so different and appear to us as odd, “backward,” and “ignorant.” One should try to understand families “from within” and to see the relativity in cultural practices of the family in front of us and try to take into account one’s own cultural biases and beliefs as well.

Cultures Are Not Better or Worse

There is no indication that some cultures are “better” than others, in general or in every respect. As we describe different practices, it should become obvious that each culture reinforces and promotes the development of certain attitudes, practices, and beliefs that are passed on and tend to promote a “the best possible way of life” for its participants. We take a “relativist” point of view in which each culture tends to shape groups and individuals in such a way as to survive and thrive within that framework. There is a tendency to one’s beliefs as practices as “natural” the “way things should be” as well as those of others with some estrangement or suspicion, if not disapproval.

In the nineteenth century, many intellectuals and writers from the European perspective tended to see groups from Africa, Asia, and Latin America as “primitive” or “savages.” In other words, as people who had not developed in the way they “should “and which were seen in need of being civilized or colonized by a superior culture, or a dominant group so they could abandon their backward beliefs and adopt the better ones. Based on that belief, in Australia, Canada, and the United States, dominant Caucasian groups

proceeded to "civilize" the Native American populations and promoted the European cultural values, imposing them even on children. It was thought better for the children to become "like us" the dominant group and to abandon "ancient traditions" that anchored families in the past. The obvious assumption was that it would be better for the children to be more "like the White children" and to adopt their values and an identity things included things like abandoning their original language, foods, habits, and values and adopt the "new and better ones" (Davis 2001). History is full of examples of a dominant group settling or conquering another country and attempting to "erase" the local culture and substitute it for a "better one."

Historically, the representatives of various national or cultural groups claim that their own culture is the best, the most advanced, etc. In the United States, it is customary to hear representatives of various government agencies or politicians to say that the United States is "the greatest civilization that has existed" or "the greatest civilization on the face of the earth." This also applies to other countries, particularly in the past, in France and the United Kingdom, and local politicians in many others extoll the virtues of their own country.

The claim mentioned about the United States ignores the many problems that affect the country, the social inequalities, the high rate of poverty among minority citizens, the large number of people in prison (Petit and Western 2004), the epidemic of drug abuse, the violence in large inner city areas leading to many killings, etc. In other countries, governments and officials make claims that their culture is "the oldest civilization", "the most important cradle of democracy," etc. This could be called "national pride" or "ethnic pride" (Smith and Kim 2006), and at times intense pride is related to xenophobia, or the feeling of devaluation of "foreigners," however they are defined. There seems to be a recent increase of xenophobia and national pride in many European countries and in the United States (Yakushko 2008). There is a surge of "white supremacy" groups, which have numerous followers, both in Europe and America. This at times includes neo-Nazi elements that complain about the "invasion" of their country by immigrants and refugees, particularly from the Middle East, Africa, Latin America and other areas of poverty, political conflict, or wars.

The father of a baby that came for treatment due to the baby's excessive crying, revealed that he had discovered after migrating from Egypt to the United States that he had been very disappointed. He said that throughout his childhood many teachers had imbued into him a great national pride. He had been taught that Egypt was the greatest country and that people from all over the world, on learning he was Egyptian, would be in awe and admiration, extend favors, and prefer him over other people, because he came from the best country in the world, the cradle of civilization. He had soon realized that this was not the general perception of Egyptians in the United States. In fact, he was facing fear and at times rejection because of the color of his skin and particularly because he was a Muslim. The reality was in sharp contrast with what he had been taught in his own country. This was quite an adjustment for him, who had not been exposed to the perceptions of people in other countries. He felt his teachers had lied to him.

Why Focus on Others' Cultures and One's Cultural Beliefs

Having said that there is no such thing as "uniform culture" to a specific country, nation, or ethnic group, given multiple variations by region, language, habits, etc., one might wonder what would be the point in trying to describe anything about a certain culture in which a person grew up or belongs to. While in the individual case, an assumption could be quite wrong and would need to be confronted with the uniqueness of each person and family, some understanding of certain guiding points, commonalities, or traditions that tend to be commonplace is useful to understand what is in front of our eyes, as in this example:

A young woman from Sudan was referred for a mental health consultation due to depression and anxiety, and she went with considerable

skepticism and suspicion. She seemed anxious and guarded during the first session. It had been reported she was not gaining weight during her pregnancy and had multiple stressors, financial and relational ones. She was from the North of Sudan and a Muslim. She came accompanied by her husband, was wearing a hijab, and seemed very burdened. She first let her husband talk and deferred to him when asked any question. As it was explained that we wanted to hear her own thoughts, her husband told her she should speak for herself.

During the taking of history, when she was asked how the marriage to her husband had come about; she was puzzled. She said that her husband had been chosen for her by her family and the marriage was arranged, to a somewhat older man. The question of "love" did not enter her world view as a factor in marrying her husband, who had been selected for her. She informed the clinician that in her social group, girls cannot have "a boyfriend" as they might do in the West. Dating would be unthinkable and simply was not done. When the clinician looked at her hands, the tips of all her fingers were colored in black with henna. The psychiatrist, who had not dealt with patients from Sudan, was at first somewhat shocked by the color of the fingers and thought that perhaps this woman exhibited an "odd behavior." When he asked about this, the husband informed him that in their culture, having the fingers colored like this means that a woman is married and therefore "no longer available." After learning this, the clinician felt some empathy for the condition of the patient in front of him, an immigrant who was seen as "very different" or even with suspicion. Now she was here, found herself pregnant and having to be treated in a public hospital where many of her beliefs were going to be seen as strange and unusual. He had avoided shaking hands with her on the first encounter and knew that she could not be alone with a male clinician, but someone had to be with her, such as her mother, a brother, or her husband.

Understanding these "codes" of behavior and practices helped to put in perspective the situation of the young woman, who had little control over her life and had migrated to a country where she felt "safer" but which was very different from her own, and she could not communicate readily because of language limitations. Furthermore, her actions were largely dictated by the norms in her social group. If one had been more acquainted with her customs and world view, this might have contributed to a quicker or better understanding of how she might feel at this stage of her life, expecting a baby and being separated from her social matrix, so to speak.

Being confronted with very different culturally based practices should also help clinicians to question their norms and beliefs, their own assumptions about normality, what is desirable, and how one should behave. Even when faced with patients and families from the "same country," they might have nevertheless beliefs, desires, concerns, and worries that are part of a cultural framework that may be very different from that of the clinician.

In multiple clinical scenarios, different cultural beliefs might "clash" or confront each other, leaving parents uncertain as to the best course. The father may have a set of culturally based beliefs, the mother a different one, and other relatives still their own traditions, everybody giving opinions with the best intentions; the clinician may have his or her own cultural practices that are also put into question:

A young woman seems anxious and uncertain. She lives with her husband and mother- in-law in a rural town in the Midwest of the United States. She is Caucasian and had a baby 3 months ago. She comes to consultation because she is worried that when she puts her baby in the crib, he cries a lot. She would not mind carrying him in her arms more of the time, as the infant clearly calms when he is held. She is, however, worried because she is criticized by her mother-in-law, who has warned her strenuously that the baby would be "spoiled" and would cry more if she gets him used to being held "every time he cries" and eventually she would make everything worse. Her husband is torn between the two women; his own instincts tell him that his wife and he should also hold the baby more, but he thinks his mother might "know best" and does not know what to

do. His mother has "always encouraged independence and self-reliance" and insists that this should be taught to a child from the very beginning. As we discussed the "cultural beliefs," fairly common in the United States that children should at all times be encouraged to rely on themselves, the young parents were reassured. They realized that for them, this issue was not so important at this moment, and they preferred to hold the baby, as they could not bear to just "let him cry" when he was so small. The young father said he could discuss the question with his mother and convince her that they were going to do things differently. The young mother was much reassured.

Blindness to One's Culture

People acquire a number of behaviors and beliefs within their social group in which they survive, thrive, and try to be as successful as possible within that social group. These practices often are seen by the members of that group as "natural" or "ideal" for human functioning. The less a person is exposed to other ways of relating, thinking, communicating, etc., the more he or she is likely to view his or her own culture as the "way things should be," logical, understandable, or even ideal. There may be a tendency to see other practices as suspicious, too foreign, or not adapted to "our way of life."

It is much easier to see problems in a culture "different than ours" and harder to explore the problems, biases, and prejudices inside which one lives. For most people in the United States, for instance, it would be puzzling why the "caste system" in India survives in the real world despite its official prohibition. Why should it be that one is "born into a caste" and this is a fate for the rest of one's life? One could be born as an "untouchable" or as a "Brahmin," and this determines lack of opportunity and rejection or being destined to have the best opportunities, respectively. One would think it is inconceivable that people believe in such things and that one's birth into a certain family marks one's opportunities, chances to marry, profession, social group, etc. However, as Kozol wrote many years ago (Kozol 1991), the United States, like many other countries, may be seen as a country with "savage inequalities." In many cities in the United States, there are areas (which some call ghettos) with mostly minorities (e.g., African-American or Latino) in which the "destiny" of the person is fairly weighted in a certain direction, not by laws but by realities, due to lack of opportunities and accumulated disadvantages: poverty, living in a high-crime area, poor schools with fewer educational materials available, plus many adversities in everyday life, which make it hard for the child to see him or herself as a candidate for higher education. There are similarities between both systems, the caste system and the "social inequalities" system. The same could be said of female mutilation which is widely perceived as aversive and strange in cultures which practice infibulation or clitoridectomy, but we do not think it unnatural that in many countries in the West, infant boys undergo circumcision either for religious reasons or even if the parents have no religion at all, for "health reasons," which are questionable.

In many European countries and other areas of the world, children are guaranteed health care by the society at large; in the United States many people find it acceptable that millions of American children do not have health insurance and have enormous difficulties accessing medical care. There are multiple examples of a similar nature as many practices within the culture are seen as reasonable, acceptable, or natural but which seen from the outsider's point of view might seem puzzling, unfair, or unacceptable.

The picture of "modern" and "traditional" societies is a complicated one. There are still enormous regions of the world in which people live in conditions of deprivation, such as lack of enough food, access to services, health care, poverty, etc. In those circumstances, their "traditional" cultural beliefs and practices help them to survive, adapt, and cope with those circumstances. It is very probable that many of those cultural patterns would change if the material conditions could be improved, and they would become more "modern" if there were less uncertainty about child survival, maternal mortality,

death from infectious diseases, etc. (WHO 1996). One also may tend to idealize traditional cultures, with their support from extended families, their protective factors such as religious beliefs, having a strong social network of support, etc., but their difficult material conditions should not be overlooked. Similarly, in "modern" Westernized cultures, there is much more opportunity, access to services and to education, etc. and at the same time drawbacks, like the loneliness of the individual, social isolation, and diminished access to old cultural markers, such as traditional celebrations, and beliefs that guide people's lives.

Other Manifestations of Cultures

The observer of the attitudes of a social group, of the way people move, their social interactions, rituals, celebrations, responses to events, etc. has to be careful to try to understand the meaning of what he observes. There are multiple variables that have to be taken into account when considering what are the "practices of a cultural group." One caveat is that the observer cannot assume that people behave in the same way "inside" their home as outside the house, in the presence of others. An anthropologist studying "macho behavior" in Mexico City among men observed that outside of the house, men tend to do little with the baby and appear to leave the care of the infant entirely to the mother "as it should be." However, inside the house, once the anthropologist had gained their trust, the picture was very different, as fathers tended to tend to the baby, feed, change diapers, and do house chores as well, contrary to what would be expected from a "macho man" (Gutmann 2006). There is a "public persona" and another one inside the house. One cannot assume that what one observes is necessarily what people do privately: what they say may differ from what they do. Similarly, what people say or how they explain their behavior, the reasons given for a certain action, might be just conscious explanations (as opposed to acting in that way for unconscious reasons) or socially desirable accounts of what is observed or believed, and in private the person might have very different true opinions.

A clinician would be interested in distinguishing between conscious ideas and motivations, and unconscious ones, which often have more explanatory power. During the Weimar Republic period in Germany, Erich Fromm, then from the Frankfurt Institute for Social Research, used questionnaires to inquire about the likelihood that workers would endorse fascism and an authoritarian regime. In analyzing the responses, a distinction was made between ostensible content of answers and their possible latent meaning (Fromm 1984).

Many people, for instance, might say that they give their baby or toddler a balanced diet and that the child "does not eat very much," despite their son or daughter being obese. When one observes the actual mealtimes or what parents do in reality, the picture might be very different. The parents may not realize the nature of what they are feeding their child, the amount, or the frequency. A woman with whom we worked who was quite obese herself, like her preschool-age child, thought that perhaps the "smell of the food' was what was making her son overweight, as she was convinced that the child did not eat very much, a fact denied by the direct observation of the child during the office visits, who would come with multiple snacks and constantly request sodas and sugary beverages.

The lesson is that there are several explanatory levels to the word "culture," from the expressed opinions and values of a person, to what they actually do and to things they are unaware they believe or are doing.

Culture: The Body and Its Movements

The body is a biological and also a cultural entity (Cohen and Leung 2009). Therefore, its manifestations and activities in everyday life reflect our animal/ethological nature but also our cultural selves. It is debatable whether there are truly "universal" patterns of body movements which are rooted in our biology and evolutionary past (Eibl-Eibesfeldt 2004) such as the flashing of the eyes from a mother to a baby in order to get his attention to the face of the adult, raising of

eyebrows to greet infants, raising intuitively the tone of voice when one is talking to a baby, or carrying a newborn mostly with the left arm (Donot 2007). All of those behaviors and attitudes have been considered as "intuitive parenting" by Hanus Papousek and his colleagues (Koester and Koester 2005), i.e., a behavioral repertoire seen in most cultures that have been studied, although one could not affirm categorically that they occur in all cultural groups. Nevertheless those behaviors are widely spread and seem largely "biologically programmed" in response to characteristics that adults perceive in babies. However, there are other body movements, attitudes, or corporal manifestations which are rooted in culture and which have a symbolic meaning or representation, or they "communicate something."

Movements and actions of the body may be quite different from one social group to another to the point that an action that in one society is considered gracious and polite or neutral but might be considered as rude or an insult in another group (Victor and Robert-Lamblin 1989). If we consider for instance table manners, in the Northern European-influenced world, it is considered polite to keep one hand on the lap while eating, while in many areas in Latin America and Mediterranean countries, this is considered rude, as both hands should be on the table while one is eating. The same could be said about "burping" at the table and slurping while eating, which in China and Japan are often considered manifestations that the food is good but elsewhere are considered a social faux pas. Something similar occurs with the sharing of food during the meal, without asking, as an implicit act of sharing and connecting socially, i.e., a person putting part of their food into another person's plate. There are multiple additional "bodily actions" that have a meaning which is assigned by the cultural group (Turner 1982) and represent something, which must be ascertained by the person not familiar with that particular social group.

A clinician faced with a family would be wise to consider these variations in order to understand the nature and meaning of interactions observed, for instance between family members. For example, an important issue that often is difficult to read in Westernized or modern societies is eye contact. Young children in many cultures are not approached making intense eye contact, or an "encounter of the gazes," as direct eye contact is discouraged between children and adults or between people in general, except for specific encounters. In many African societies and groups from India, for instance, eye contact is avoided because children show respect to adults and try to avoid looking at them in the eye, which is a cherished behavior in the Western world and an important social skill that is carefully cultivated by adults with children. Something similar occurs with the notion of "talking to the baby," which in some cultures is considered unnecessary during the first few months of life, as the baby "would not understand" and which in the Western world is now considered as a marker of positive maternal or paternal behavior, which helps the baby regulate emotions and promote language development.

Language and Culture

Different cultural groups also use spoken and gestural language in a unique way, to communicate different things, a variety of emotions, mixtures of emotions, and states of mind. An expression like "I am doing it for the face of God" has a deep meaning in Arabic, and it can be translated as "doing something for nothing" or for filial piety. However, the translation is inadequate in the sense that it does not capture the religious dimension that may be so profound in Islam. This is true with many other figures of speech, metaphors, and storytelling. Although they can be transferred to another language, the listener may not get the full meaning and the beauty of the original language and cultural representation.

It is said that some languages have multiple words for "the same thing," like "types of snow" among the Inuit or "types of grass" in different countries. If this applied to cultural phenomena, the translation of complex emotions can be difficult to transfer from one language to another. In

some languages there are more "somatic" descriptions of emotions, rather than purely mental or emotional words. Emotions can be communicated aptly by describing a body sensation, such as "butterflies in the stomach" or "my soul is shrinking" in Spanish to indicate fright. These issues when properly understood can add a lot of richness to the narratives of life stories and descriptions of relationships or internal states in clients from different cultures. It is not only the language but the symbolic meaning of the expressions that can dictate different forms of somatization of emotion, such as someone being "a pain in the neck" in English or "not being able to swallow certain bad news" in Spanish which at times is manifested as globus hystericus (the sensation of having something stuck in the throat and not to be able to swallow properly or get rid of the annoying sensation).

Some emotions can be difficult to understand across cultures, for instance a Japanese man who suffered a lot seeing his child very ill chronically explained that he never talked to his wife about his feelings, and she did not know how he felt inside either, as everybody's pain is only for the person "to endure." Enduring is a cultural value that denotes strength and resilience in the face of adversity. This quality would be hard to understand as a value for a person from a Westernized culture.

Other things difficult to define are for instance "the Chinese way" or "Indianness." In a study with parents from India (Saraswathi and Ganapathy 2002), many parents wanted their child to achieve "Indianness" and thought that the child has innate predispositions and tendencies that cannot be changed significantly and that the destiny has to be fulfilled. Also, a good child is considered one with strong values, who is obedient and respectful to his or her parents and other elders, and who tells the truth and is modest. Compassion and tolerance were highly valued; 605 of Gujarati parents ascribed to those traditional values. A good child is often called *sanskari* (literally "civilized," in reality meaning obedient, conforming, and respectful). This includes to carry out one's duty throughout life and keep one's place in the family; this often is referred as "dharma" (literally "religion") but meaning to do what one should do.

Culture, the Perinatal Stage, and Early Childhood. Some Dichotomies and Absolutes

Being Dead or Alive

For a person who has grown up and been educated in the Western scientific traditions and logical thinking, it may be surprising to discover that people from other traditions do not think the same way and do not make certain distinctions. For instance, as Manuel Honwana (2002) describes, many people in the South of Mozambique do not make a distinction between being alive and dead in the form that people in the Western world do. That is, being "dead" does not mean to be "gone"; the spirit of the person, in a very physical and concrete way, is still around and exerts influence in events, behavior, moods, and other natural phenomena. The presence of ancestors and spirits, people who "have died," has to be considered and taken into account as though they were alive from our point of view. The spirits have to be contented, appeased, honored, or satisfied. This is the same in many other traditional societies. The point is that "dying" is not an absolute transition but a mere passage to another state, and the person is not really gone. In fact, the spirit can assume special powers: to punish, to make people feel certain things, or to act in unique ways. This is particularly true in possession by spirits, which is a fairly universal phenomenon. It is important to understand that the distinction alive-dead is not as clear-cut as we imagine in the West.

The perinatal period and raising young children generally are stages of the life cycle in which there is a very strong reliance on traditions, cultural practices, and behaviors that might promote an optimal outcome of the pregnancy. We traditionally think that a woman is either pregnant or not pregnant. Even in Westernized cultures, it is recognized that a woman can exhibit pseudocyesis or "phantom pregnancy." In this state the woman is convinced that she is pregnant, and psychologically she is, even though there is no fetus inside the uterus. The woman experiences breast growth, abdominal protrusion, and cessation of the menstrual period, "as if" she

were pregnant. It may be quite difficult to convince a woman that she is not pregnant as her body "tells her" that she is. In some traditional cultures, a woman may be "a little pregnant" and have the "beginning of a pregnancy," so the phenomenon is not an "all-or-nothing one" but a possibility that may prosper or be frustrated depending on the satisfaction of certain requirements, performing rituals, and respecting taboos and destiny, among many other determinants.

The idea of a "continuum" offers a number of possibilities, from the duration of a pregnancy, to what can happen to it, if it can be slowed, detailed, put on a state of suspension, or accelerated. All of these presentations are observed in the clinical setting but also have a cultural representation. In India a state described as "pregnancy with puppies" has been described in men; when at times a man has been bitten by a dog, a state of pregnancy with dogs, literally, can ensue as a consequence. The condition can also occur in women. (Chowdhury et al. 2003). In the case of men, the birth of the puppies would be expected to occur through the penis.

Who Belongs in the Baby's Family and Who Does Not?

The definition of what a family is clearly is determined to a great degree by the culture in question. Most babies are "born into families," and a number of rules and traditions dictate who "belongs" in the family, what their role is, and what can be expected from them to ensure the survival of the baby and his or her development according to certain principles and expectations.

Recently, a preschool-age girl from a Latino family was asked to "draw a family" as a part of the exploration as to what is in her mind, who is her family, etc. Most children in the Western world would draw a mother, a father, and children, usually siblings. Rosa, the 4-year-old whose concept of family we are describing drew her mother, her grandmother and grandfather, several siblings, several cousins, and several aunts and uncles. A notable absence was her father, and she added two dogs. This is "her family."

Also, dealing with many African-American families in the Midwest, at times expecting moth-

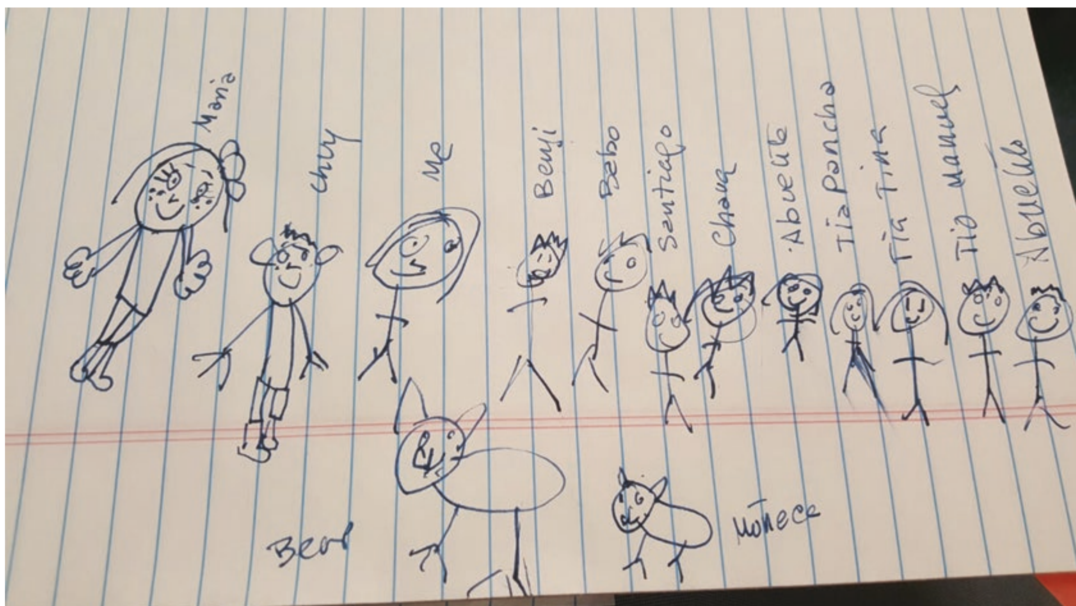

Fig. 1.1 Drawing of her family by a six year old girl hispanic girl

ers would come accompanied by family members who were introduced as "my sister" or "my aunt," but when one would explore in detail, they turned out to be what we would call friends or neighbors. When the expecting woman would be asked to describe the actual relation, they might say "she is my play sister" or "she is my play aunt." A very important distinction to our mind was not at all important in other people' mind, as these were part of the concept of an "extended family" (including friends) that has existed for generations, of families often in poverty in order to support each other and survive.

In a similar way, the clinicians' assumptions about parenting and who should spend time with the baby at times are challenged: when a young mother would advise that she had "allowed the newborn to spend the night with a godmother" because the godmother wanted to bond with the baby. This young mother felt she welcomed the chance to be without the baby and wanted the baby to have additional caregivers in his life as she thought "one never knows what can happen." In her environment there were frequent killings as she lived in a very impoverished area of an inner city in the United States.

One of the underlying themes appeared to be to extend the circle of people who might be available to help the baby if need be and who could be considered as "family" even when from our eyes they might only be friends, godmothers, godfathers, etc.

Similarly, in many cultures in Africa, it seems that there is a more "communal view" of who should take care of babies, and a number of women in the vicinity could take care of each other's babies when a need arose, even providing milk, food, or care. It appears that in those circumstances, the babies become used to multiple caregivers within limits and feel comfortable spending time with them.

In the Western world, there are also "new families," or new types of families, which consist of "blended families," i.e., a child who is born to parents who have had previous marriages and children and established a new family with "his children, her children, and our children." Increasingly, a young child might have to learn that he has biological siblings, half siblings, and stepsiblings, as well as more than one stepfather and stepmother, depending on the number of marriages of each biological parent.

People increasingly appear to see themselves as having more freedom to divorce and remarry, without all the taboos and stigmatization that were commonplace even two generations ago. Also, a baby could be raised by two lesbian mothers, two gay parents, or to be the product of a surrogate pregnancy. Clinicians have had to learn to be flexible in considering what a family is and how to deal clinically with these new models of family. In these circumstances the "traditional models" need to be updated, changed, or discarded with the new realities all over the world. Much has to be learned about the effects and strategies to deal with these "new families" or broadened definition about what a family is.

Among Muslim families, particularly in the Middle East, a taboo that is common in families of European origin is not observed, namely, the marriage between first cousins and other members of the extended family (Zlotogora et al. 2002). This leads to a higher prevalence of some genetic disturbances due to the consanguinity, and the pattern of marrying relatives seems to be declining in the newer generations.

In many countries due to multiple factors, such as infection with HIV AIDS in adults and also given the epidemic of drug addiction in the United States, many children are raised not by their parents but by one or more grandparents (Bengton 2001), which presents a new perspective for the traditional concept of family.

Cultural Awareness, Sensitivity, or Competence

The diversity and variety of cultures are so vast that it would be very difficult to comprehend many of them. Simply in India or China, hundreds of languages are spoken, there are multiple ethnic groups, and people from one area may not be able to understand the language of a province

nearby. They may only be able to communicate through a "lingua franca" such as Mandarin, Hindi, or, in other continents, Arabic, Swahili, English, or Spanish, which are spoken by millions of people. But the peculiarities, unique beliefs, ways of acting, and dealing with children are at the same time quite varied and, from a broader perspective, very similar. The paradox of cultures is that one can relate to different cultures by focusing on the human experiences and commonalities, such as expecting a baby, giving birth, and taking care of a small child, hoping to produce a "good person" in the end.

The specifics, however, of each culture are very difficult to grasp in their entirety except through "immersion" or prolonged exposure to a given culture. Nevertheless, often people from different cultures would be interested in explaining their frame of mind, beliefs, attitudes, and expressions if the clinician is involved truly in their lives, tries to understand them, and "makes room" in his or her mind to the possibility of different points of view, ideas, and values. Of course, it would be useful for the clinician to learn as much as possible about the history and culture of people from a certain population with whom one will work, such as Turkish people in Germany or the Netherlands, different Indian immigrants in Australia or the United Kingdom, or Somalis in Minnesota, immigrants from the Middle East in Michigan, in the United States. One should also highlight the differences and commonalities in the case of "internal migration," i.e., people with the "same country" and the "same language" but who may migrate from the countryside to the city and experience almost as intense a cultural shock as people moving from a distant country. One of the dangers in working transculturally is to pretend that "there are no differences" between people and that "we all believe he same things" or want the same things for our children. The challenge of cultural competency is a tension between seeing what we have in common with people from "different places" and also waht the differences are, in order to understand other people as much as possible, "from within." Generally, families and individuals appreciate a clinician who makes a little effort to learn a few words in their language or has read some about their country or ethnic group and is interested in learning more as it relates to the clinical work at hand.

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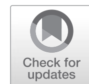

2 What Parents Want for Their Children

J. Martin Maldonado-Duran
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What Parents Want

What Do Parents Want for Their Children?

This chapter approaches the question of how common or different are the wishes that parents have for their children, from the beginning of life, and how these wishes can be understood in a cultural context. This issue is important because it allows to put in perspective different parenting practices, what parents believe, and how they go about promoting or discouraging certain attitudes and behaviors in their children. Although it is tempting to think that "all parents want the same," this is not so in terms of specific features and strategies of parenting as parents want different things from their children in various cultural settings.

One basic assumption is that there are not necessarily "universal" goals that all parents have for the growth and development of their child. Probably most parents in the world would say that they hope their child would be happy and healthy and be a productive member of society.

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Immediately, the details come to the fore: What do parents mean by *happiness*? What is health, particularly mental health? And how does one contribute meaningfully to society or the world? It seems important to describe the hopes of parents vis a vis their children, how they define "success," and what attributes or character traits would prepare a child to succeed in a particular culture.

The attitudes and characteristics that parents value most dictate, to a large degree, how they raise their children and what they will discourage in them. A different society will reinforce or reward different attributes that are considered as "more desirable" for boys or girls. These are often in line with the philosophy of child care centers and preschool programs in those societies where they exist.

What Parents Value Most

Several studies have looked at what are the most common caregivers' beliefs about parenting, what traits they want to promote, and which ones they think are undesirable in their children. For instance the International Study of Parents, Children, and Schools (ISPCS), the International Baby Study (IBS), and earlier studies of Dutch and US parents (Harkness et al. 2000) have focused on these issues.

In the United States, a relatively recent study revealed that American parents are very interested in the intellectual development of their

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children, and when praising them, they emphasize how intelligent and inquisitive they are (Harkness and Super 2002). Parents tend to welcome anything that can promote intellect. Parents in Nordic countries of Europe tend to emphasize more the importance of happiness and being content. These parents want to help their children with an emphasis on routines and predictability in their lives. A study conducted with 60 families comparing the strategies and beliefs of Dutch and American parents (Harkness et al. 2000) showed that there is really not a unique "Western mindset" as a uniform and unwavering mindset emphasizing individualism. They found that Dutch parents value entrepreneurship and autonomy while the child also maintains a strong connection to the family, while at the same time they value if the child is determined and strong willed.

Parental Hopes

There may be some "universal" values in child rearing that are encountered in most cultures. For instance, in all of them, children are encouraged to learn to talk and expected to do so (Quinn 2005). There are, however, ample differences on how early and *how much* children "should talk" – or should be talked to – in order to promote their language development. Also, in all cultures children eventually are hoped to learn to walk, run, and play, as well as achieve some degree of toileting self-control.

Most parents would say they want their child to be healthy and to grow to be a good person, the meaning of which would depend on the culture. Even some diseases might have a varied meaning in different contexts, in the case that the child is not "healthy." For instance, in Europe in centuries past, epilepsy was considered as "sacred disease" (Magiorkinis et al. 2010), or a condition of divine origin. This idea of divine origin also was present among the Aztecs, in which epilepsy was brought about by the goddess Tlazolteotl (Ladino and Tellez-Zenteno 2016) and in India by the goddesses Shiva and Apasmara, while in Germany Saint Valentine was thought to be able to bring it about and make it go away. In modern times, among some Hmong families, the fact that the child has seizures might mean a certain communication and a special relationship with spirits or ancestors (Faddiman 1998) and therefore is a blessing at the same time as an illness. The parents of such child may not wish to "eliminate it" because this is interfering with designs from the other world.

Other wishes of parents for their children might be much more dependent on culture. If one asks Caucasian parents in the United States how they want their child's future to be, it is likely they would say they want their child to be happy, a productive citizen, able to provide for him or herself, to marry and have children, fulfilling career goals, to be independent, and have financial stability. Parents from a different background might have other wishes. A study with parents form India (Saraswathi and Ganapthy 2002) showed many parents wanted their children to achieve "Indianness": many parents think that the child has a uniqueness that is inherent to him or her, that the child has innate predispositions and tendencies that cannot be changed significantly, and that their fate has to be fulfilled. Obedience, politeness, compassion, and tolerance were highly valued: 60% of Gujarati parents in this Indian survey ascribed to those traditional values. A good child is often called *sanskari* ("civilized"); in the real world this is equivalent with being obedient, conforming, and respectful. These qualities include that the individual must carry out his or her duty throughout life and keep one's place in the family. This often is referred as *dharma* (literally "religion') but meaning to do what one should do. Being bound to duty and traditions does not depend on whether the person wants to do those things; they are their duty.

In a recent survey exploring the parental opinions in 16 countries conducted by HSBC Retail Banking and Wealth Management, further insights were obtained on parent's hopes for their children. The survey was called "The Value of Education: Learning for Life" with some "candidate wishes" that parents might have for their children; these were some of the options: (1) to be happy in life, (2) to lead a healthy lifestyle, (3) to earn enough to enjoy a comfortable life, (4) to be successful in one's career, and (5) to fulfill one's potential. In France and Canada, the highest-ranked wish was for children to be happy in life, while in India, it was second to be

successful in one's career, the same as in Malaysia. In Turkey it was more important to lead a healthy lifestyle, and being happy in life was second. In the same survey, 83% of parents had a specific occupation in mind for their child, the most popular wish was that the child study medicine (almost a fifth of parents), followed by engineering and computer science. It is important to mention that this survey did not include African countries (and only Turkey in the Middle East), plus India, China, Australia, and Malaysia.

A survey conducted by the Pew Foundation in the United States (Pew Research Center 2015) suggested that *responsibility* was the quality that most parents want their children to learn; the capacity to work hard was often mentioned alongside responsibility, representative perhaps of traditional Protestant ethics (Berger 2010). The survey included 1807 adults with children younger than 18, in a national representative sample, in which parents were asked about 12 values they might want to instill in their children. Less important values were empathy for others, tolerance, persistence, curiosity, obedience, and religious faith. For "conservative" parents (from the political point of view), obedience was very important. More "liberal" parents ranked empathy and curiosity at a higher level. Less-educated parents tend to place more emphasis on obedience and religious faith.

The Pew survey also showed parents of lower income expressed concern that their child could be a victim of violence, could be kidnapped, or could be shot. Half of all parents worried that their child might be bullied at school or suffer from anxiety or depression sometime in their life. As to the family composition, large percentages of Caucasian and Asian American children were living in a two-parent home, while this was true of only 31% of African-American children, and over half of these were living in a single-parent family. Parents of younger children tended to feel more personally responsible for their child's achievements, and more mothers (62%) than fathers said they could be overprotective. On the question of whether parents are too involved in the lives of their children, there are sharp differences by ethnicity. About 75% of African-American parents and 67% of Hispanic parents say a parent can never be too involved in a child's education, but only 47% of Caucasian parents think that. More educated parents tend more often to read to their children every day, but only a third of less-educated ones do so.

A significant proportion of parents in China experience much pressure to ensure that their children have academic success and are competitive. Parents place a great deal of emphasis on this as a measure of their parenting and the performance of their children. A survey with over a thousand elementary school children in China suggested that a great majority of children, over 80%, are very worried about examinations, fear their parents' reaction to "failure," and had endured physical punishments at home due to these perceived failures. About a fourth of the children complained of psychosomatic symptoms, particularly if they experienced a high level of stress, suggesting an effect of very high and intense parental expectations. The pressure could be much more intense in families with only one child, as it was the previous policy of the Chinese government (Hesketh et al. 2010).

What Is Success? How Is Happiness Defined?

How is success measured? It could be by wealth acquisition, happiness in living with a family or at work, the ability to relate to others, or simply "feeling happy" (or subjective well-being). What in one culture is considered success could be very different from another. This may depend on the norms of families around them, the material conditions, and what the family is exposed to in their surrounding and the ideological values, such as those imparted by mass media of communication.

The immigrant Vietnamese mother of a boy was very puzzled with her son, who was now 12 years old and who had been born in the United States. The mother was single and a very hard worker. Her son was depressed and complained intensely that he did not have friends and that he was not accepted in the group of middle-school peers. He felt alienated and quite sad; he lived in a Midwest City of medium size. As he would start to cry, his mother was very confused and disapproved of his tears. It was very hard for her to

understand that the child felt so sad experiencing the rejection of not being liked and ostracized. She finally said "Why should you cry and be depressed? You have a bed, you have shoes, you have food every day!" she really meant that these were the most important things in life and he should be happy.

Obviously, when parents have experienced a lot of poverty, war, persecution, state terrorism, or multiple adversities during childhood, it may be hard for them to empathize with their children, who may have "real problems" but which pale in comparison with their parents' life history.

There have been several surveys attempting to measure the level of happiness of children and adults, surveys supported by the United Nations. This is a correlate of the "success" of parents in the various cultures. The surveys consistently find that people in Nordic countries and the Netherlands are the "happiest." Children there generally like to go to school, to learn, and feel content for the most part. Strikingly, visitors to very impoverished countries or regions note with surprise that sometimes the children "seem happy" despite living in very materially poor conditions, with few toys and with little entertainment that is commonplace in the developed world, such as laptops, tablets, or smart telephones. This suggests that happiness is correlated but is not totally dependent on material possessions and wealth, but on multiple ingredients.

If what is considered happiness is influenced by the social environment (Triandis, 2000), it is pertinent to ask what the main ingredients of happiness in different cultures are (Ivens, 2007). A recent study compared young people's definition of happiness between American (United States) and Chinese respondents. The survey found that the American respondents were more often focused on pleasure, on the "here and now" and on enjoying life, and that the youngsters thought more individualistically. The Chinese respondents defined happiness as a life that is "balanced" between duties to family and self-satisfaction or achievement, finding meaning in life and contributing to society (Lu and Gilmour 2004). The definition of self in each case might be different, a unique person with individual goals and aspirations and successes in one case and an interconnected self, bound to duties and to others, as the ideal self in the second case. A similar dichotomy was found in a survey of German and Black South African college students, the latter making much more references to social connections and family relations as crucial to happiness (Pflug 2009). It must not be overlooked that these ideals and values may also have a negative side (Inglehart et al., 1998). Much independence, self-interest, and pursuit of one's goals could lead to isolation and loneliness, while too much interdependence may lead to a person feeling "trapped" in a network of relationships.

A similar finding was obtained in a study by Uchida et al. (2004) in which the Asian respondents defined happiness as a balance of emotions, while US respondents focused more on individual achievement, self-esteem, and personal success. On the other hand, too much focus on "what other people think," of one's image, and of one's place in a social group can lead to shame, guilt, and depression (Bedford and Hwang 2003).

A frequently used measure with children is the Oxford Happiness Scale (Hills and Argyle 2002). The scale contains questions in five domains: mastery, self-fulfillment, satisfaction with life, vigor, social interest and social cheerfulness. To some extent these are socially constructed criteria for happiness, but there is research in several countries with its use (Meleddu et al. 2012). This scale may or may not be applicable in poor countries or in very different cultures than the Western European ones. Despite this, there may be an association between greater happiness in school-age children and being more extrovert, more socially oriented, and more energetic. This was also found in a small study in India (Holder et al. 2012). The question of extraversion vs. shyness or timidity is an important one, as it is a virtue or valued quality in many cultures, particularly for men. In many cultures, particularly traditional ones, shyness and quietness in girls are valued, while being outgoing and opinionated is discouraged. A close relative of happiness is the concept of child "well-being" which has been studied in multiple countries (Pollard and Lee 2003; Stratham and Chase 2010). A comprehensive set of terms to define well-being includes several realms: physical, psychological, cognitive, social,

and economic. There is however less agreement on how to define well-being in each of these domains, which cannot be only the absence of negative contents, e.g., abnormalities in physical condition, psychological disturbance, etc., but which must include positive indicators of mood, resilience, cognition, etc. The measures can be “objective” as well a subjective, i.e., asking children and their parents about their level of happiness and contentment. In the economic area, most experts would agree that well-being would include the absence of economic deprivation, poverty, and the hardships associated with it. It is necessary to not embrace surveys as “the truth,” as sometimes what is applicable in one context may not transfer well to another social or cultural context, which is the issue of decontextualization and imposing values from one culture to judge another. Additionally, measuring the level of well-being of children also would require considering their opportunities for development and health in the future, not just in the present (Stratham and Chase 2010). Childhood well-being has been closely associated to “family well-being” particularly for young children (Wollny et al. 2010). In societies with very high economic disparities, a byproduct is “social exclusion,” which has a negative effect on the psychosocial outcome of children and puts them at risk.

Despite this, child welfare seems to be associated with societies in which there is less social inequality or income disparity (Pickett and Wikinson 2007). This phenomenon also has been observed for adults. Unfortunately, social inequality is on the rise in many countries around the world. Generally, child welfare is associated with greater social spending on family support and services programs in a given country. When children themselves are asked what goes into well-being, several studies have some findings in common, a sense of security, of agency (making decisions for one’s own good), and a positive view of oneself.

The Hope of Economic Success

In many social groups, a crucial measure of “success” in life is the achievement of greater material wealth. It can be in the form of some luxurious possessions (cars, jewelry, expensive items, houses, etc.) or to have a “great job or profession” at a prestigious attorney firm or to be the chief executive officer of a “good company.” This is very understandable in the abstract sense, as parents may want their children to be secure and have no major everyday stressors. However, there is some evidence that privilege and affluence may be associated with higher psychosocial risks for depression, anxiety problems, and substance abuse issues among adolescents, at least in the United States (Luthar 2003). These difficulties may be associated with a pressure to compete, to excel, to be “perfect,” and to be “a winner” or ideal in multiple areas, academic, beauty, sports, music, etc. which many children might find difficult to achieve. It might be preferable to have no major economic deprivations and stressors but without excessive pressures and worries about “growing one’s wealth” constantly. An interesting question is how much of the parental hopes are embraced by the children as they grow up. In a recent survey of adolescents in the United States (Boyd et al. 2015), most adolescents referred to their wish to be “a millionaire,” and a great athlete, and they also desired world peace.

Until recent times, in the American popular culture, very wealthy individuals, self-made men, and success stories were very much admired, and held as exemplars of success, they were the “national icons” of the collective conscience. In other cultures, people might hold in higher-esteem poets, writers, artists, and scientists and tend to be suspicious of wealthy individuals as candidates for illicit enrichment, which is rampant in many countries.

Hopes for Academic Success and Prestige

Young people in countries like Japan, Korea, China, and others face considerable pressures to compete academically and to excel in their grades. In China many parents place great emphasis on the child obtaining good grades as one of the main measures of their child “doing well,” perhaps as the main indicator. There is much pressure on the parents to ensure that their children have academic success and are competitive. A recent survey with over a thousand elementary

school children in China suggested that most children, over 80%, are very worried about examinations, fear their parents' reaction to "failure," and experienced physical punishments at home due to these perceived flaws. About a fourth of the children also complained of psychosomatic symptoms, particularly those who reported to experience a high level of stress related to very high parental expectations (Hesketh et al. 2010). In some Asian countries, given the competition between children for placements in prestigious educational institutions, many children will not have time to play, "waste time having fun," and may spend evenings and weekends in a "cram school" in order to compete and enter a prestigious college (Portes and Fernandez-Kelly 2009). The parents may be primarily focused on achievement, performance, and grades and put in second place the emotional well-being of the child. This phenomenon can be seen also in immigrant Asian communities in other countries, like the United States. In a sense it seems that the children are deprived of what might be considered "a childhood" with time to play and relax and very early on start participating in a sort of market economy where they have to compete and where the education may be geared toward "passing examinations" rather than necessarily learning (Field 1995). In wealthier sectors of the United States and among the elite of many poor countries, children have to be "enrolled" in prestigious, usually private, schools, at times starting in infancy, given the competition for places in the most prestigious settings. Parents hope their child will have connections with other "successful" families and have better chances to get ahead in life. Also, parents have the pressure to start teaching things to the very young child to promote optimal brain development, sometimes sacrificing the emotional development for the sake of teaching all the "right things" to stimulate the brain of their child in the cognitive arena.

In the most impoverished "inner city" areas of the United States, where there is a higher rate of crime and minorities (such as African-American families and Latino families), many parents hope that their child can actually *survive* to adulthood and not to go to prison (particularly in the case of the African-American males). This is so due to the high prevalence of interpersonal violence and the abundance of guns. Some of these areas can even be conceptualized as "war zones" where children and adolescents are equally victims of gun violence – as is the current case in in cities like Chicago (Garbarino 2001). Something similar might be said or other true war zones, such as the multiple areas of recent conflict, like Syria, Iraq, Afghanistan, Palestine, and Nigeria, to name a few. In countries with generalized violence where crime and narco-trafficking are rampant, and violence reigns in urban and even rural areas, parents may fear being victims of the violence and a generalized feeing of insecurity. This is common in the Latin American region (Venezuela, Mexico, Colombia, Guatemala, El Salvador, or Honduras) and many other countries around the globe.

Another wish frequently verbalized by parents in the United States, for African-American impoverished children, is the wish that the child would stay "out of trouble" and will not be incarcerated. The rate of incarceration of African-American men is higher than for other groups, and parents often explain their somewhat harsher disciplinary strategies as an attempt to control their children so that they will not engage in crimes eventually. It is well-known that in this country, there is great inequality in the rate of incarceration between Caucasian and African-American adults, at a ratio of one to six (Petit and Western 2004; Cox 2012), which is in part one of the consequences of the former "war on drugs."

In all these scenarios—in addition to those where the children have to work from early in life in precarious conditions (Mexico, South and Central America, Africa, and many other countries), it would appear that despite the parents' good wishes, childhood can be burdened with multiple expectations, pressures, and parental wishes that may in effect make childhood quite difficult.

Socialization Wishes

A recent study in Milan, Italy, with over 800 families (Barni et al. 2011) explored whether parents succeed in transmitting their socialization values to their children. The "socialization values" which had been originally studied by Schwartz

(1992) were a combination of achieving satisfaction for oneself, being "a success" and being mindful of the needs of others, respecting traditions, and at the same time being original and inventive. In several Asian countries, such as Japan, Korea, China, and others in Southeast Asia, there is much emphasis on filial pity. Children are to a larger or lesser degree taught to be faithful to and respectfully support (*feng yang*, in Mandarin) their parents. This will stand particularly when they are unable to care for themselves (Stafford 2006). This expectation applies to all children but particularly to boys and men when they become adults. Filial piety is a cornerstone of the values taught by Confucius. The parents attempt to teach their children to have concern for others and for their parents in particular. Children are taught the importance of being obedient, respectful, and useful to one's parents. The child should be glad to perform a number of concrete duties to care for the parents, particularly as they age, and do so inadvertently, with the parent thinking the child does this very happily (Sung 1990).

Similarly, in many traditional Mexican families, parents expect that children should show respect toward parents and other elders, being diligent and deferent toward them. Also, belonging to the family, loyalty to its members, and cohesiveness between them are paramount (Diaz-Guerrero and Szalay 1991).

Physical Beauty and Attractiveness

Most parents have a desire to have "beautiful children" if possible, a desire called *calipedia (*in Greek *Kallipaidia)*. During the pregnancy, parents tend to fantasize or have episodes of reverie, in which they imagine how their child will be; usually they tend to imagine an "ideal child." Once the baby is born, one faces the "real child."

When the baby is born, parents and relatives often inquire about the physical properties of the child, the gender, and whom he looks like. The "desired" characteristics have a strong cultural bias. In India (like in most cultures) a lighter skin color is favored, which is also the case in Latin America and among African-American groups in the United States. When the baby is born, in African-American families, the relatives often ask if the baby has "good hair" (generally meaning less curly) particularly for a girl. Indeed, African-American women may go to great lengths to acquire straight hair or artificial hair to give that appearance (Rooks 2000). In Latin America, the more "European" the child looks, the better. The pursuit of beauty is so desirable in many parts of the world, that in some countries, with the rise in plastic surgery, parents sometimes have to save money to provide cosmetic surgery mostly to daughters to enhance female attributes or to provide the desired nose, as in Iran or Brazil (Edmonds 2010), just to name cases in which there has been an increasing demand for such surgery. With increasing globalization, there is a tendency to adopt one standard of beauty (Gimlin 2000) generally portrayed in being as white as possible and having facial features of an "Anglo-Saxon" type (Evans and McConnell 2003); this is seen in countries like Malaysia and Iran, where girls often want a nose like that (Lenehanm 2011) but also in many other countries. Tehran has been referred to as the "nose job capital of the world," which is sought not only by young women but also men. Beauty is becoming an expectation, rather than just a matter of luck as in times past (Edmonds 2010). Colombian and Venezuelan girls often expect some form of plastic surgery as a "gift" in achieving womanhood (turning 15 or 18 years old). In Brazil there is even a name for women who have had silicone implants and enhancements: *siliconadas*.

Perceived beauty is favored in most cultures over its opposite. Parents generally endeavor to make their children look as beautiful as possible and hope their children will be at least acceptably beautiful as they grow up. There seems to be a strong, perhaps also biological, bias toward beauty in people's preferences. Young children, for instance, trust more the information given to them, when it is provided by a more beautiful person (Bascandziev and Harris 2014).

In the twentieth century in the United States, during the height of the "eugenics movement," there were beauty contests for babies, which emphasized precisely certain physical traits in them which were considered beautiful, healthy, and the product of "good genes" (Stern 2002). The eugenics movement was a trend toward

"improving" the racial and genetic features of the population by promoting reproduction by beautiful or desirable people and obstructing that of people with "defects" or undesirable traits. These were the Caucasian, "Nordic," or Arian features. These baby contests have largely disappeared, but there are still beauty contests for preschool and school-age children, or "beauty pageants," in which parents fulfill their expectations to have a child rewarded as beautiful for all to admire.

Preserving Their Inherited Identity

There is little research on what parents want for their children regarding the issue of cultural or ethnic identity and values. Do they want the children to preserve what they gave them growing up? Or do they allow them to "choose for themselves" and decide whether they want to identify with their parent's religion, beliefs, and values? This might be a particularly relevant issue for immigrants and their children, as the parents often want their children to preserve at least some of their traditional values and identity, which would be made easier if they married someone from the "same group." However, all parents face this dilemma, do they insist that the children believe the same things as they do, or do they "allow" them to choose different practices and identities?

One of the determinants of preserving traditional practices for the children is "How different" or how similar these might be compared to the practices in the social milieu in which the children grow up. For children of Latin American immigrant parents in the United States, the differences are in what language to use (Spanish, Portuguese, or English), the value assigned to the family including the extended family, closeness, dependency, and ethnic markers, such as traditions and celebrations. Despite differences, there are many commonalities in terms of beliefs and religion with families from the host countries, like the United States or European ones. The situation might be quite different for the children of parents who are "very different," which might make it more difficult to maintain at least part of their traditions and identity. To give an example, in the Sikh religion, mostly originating from the Punjab area of India, there are "five Ks" that Guru Gobind Singh (in the year 1699) instructed Sikhs to follow: *Kesh* (to not cut their hair), to wear a *Kara* (a special bangle or metal band worn on the wrist), to always carry a *Kangha* (a comb preferably on the hair under the turban), carry a dagger (*Kirpan*), and to wear baggy undershorts (*Kaccha*). Some of these are easier to follow than others. Boys may struggle in schools if they have long hair, and the dagger and the undershorts would be very difficult to preserve in a Westernized public school (Drury 1991). The same could be said for Mormon children, particularly outside of the state of Utah, who may have to wear special underwear, never drink coffee, go to religious services early in the morning before school, and have to save money to pay a tenth of their money at the temple (tidings). The children of parents whose religion is Jehovah's witnesses are expected not to celebrate birthdays or any of the "national holidays" of their country, not to swear allegiance to any national flags, and they do not celebrate religious festivities like Christmas, etc. This may lead to a feeling of happiness to belong to their special group or feeling alienated and set aside from participating in activities that other children enjoy. To a certain degree, all children have to struggle with these questions; how much to maintain of the teachings and values of their parents, conform to, and preserve them; or how much to develop their own beliefs or adopt those of their peers and friends. Parents differ in their degree of acceptance of any "changes." It would be particularly difficult if some things are forbidden, e.g., if one is practicing Muslim and one's child eats pork (even inadvertently at school). The child may feel like "an outsider," which can be negotiated successfully, but some children feel alienated and embarrassed of their origins, particularly in the preadolescent years.

The issue of being the same as one's parents or being different is not only a question for the parents but for the community. Parents may worry that their friends, neighbors, people in their church, or community might frown upon them or look negatively on their child for "being different," and this social pressure is hard to bear.

In traditional cultures, adults tend to worry very much about their "prestige," public image, and dignity, and some behaviors in their children might shame them because of these social pressures, even if they themselves did not mind that a child cut their hair, got a tattoo or a piercing, or transgressed some of the customs of the community.

The expectations of parents may be different for boys than for girls. A study in Australia with Vietnamese immigrants emphasized that girls are socialized to be obedient, to be helpful within their family, and to engage in family house chores. They are less encouraged to have a career. In contrast, boys are pressured to choose education and pursue a "good career" above all (Rosenthal et al. 1996) which girls may find unfair, exposed to different values and practices than their parents; this is similar to what happens in many traditional societies, in which girls are reared toward marriage while boys to pursue higher education and to be successful in careers.

Hopes for Marriage

In most societies, a large majority of individuals marry, and the evidence in Westernized countries suggests that married individuals are happier and healthier; they have a lower prevalence of chronic health problems (Myers et al. 2005) and even emotional and behavioral problems. In many countries the practice of arranged marriages persists, as it was in the past also the norm in most of the Western world. The notion of marrying for love is a relatively recent one, having to do with individuals' desires, hopes, and feelings. Marriage was conceptualized as a contract between families (or clans) in which there was an exchange of goods, contracts might have been involved, and the marriage hopefully increased the prestige of the family, if not its wealth, connections, influence, social standing, or was an aide to reduce tensions between groups. In cultures where this is not frowned upon, the marrying parties accept the union as their duty, their fate, or as a sacrifice to help their family. With growing globalization, the new way of viewing marriage, as a matter for individuals to decide, and for reasons related to love and emotional closeness, may create a conflict for the individuals (Zaidi and Shuraydi 2002; Netting 2006).

In countries with many immigrants, these conflicts may be exacerbated, and the young person, a child of immigrants, might be exposed to contradictory messages, torn between individual desires and family duty. The immigrant parents may hope to arrange a marriage and have a strong preference for their son or daughter to marry a person of the same religion or from a similar or higher socioeconomical status or ethnicity.

One further issue involves "success" or "happiness" of a marriage, whether arranged or chosen by individuals. In the Western world, there is a fairly high rate of divorce, indicating, at least on its face, the lack of success of the first union. Conversely, in societies with lower rates of divorce and more allegiance to traditional values, people may not divorce as often, but the question is whether they are happy in their marriage or just fulfil their duty. It appears that even in China, India, and Iran, in which arranged marriages are common, men and women have the opinion that that mutual attraction, love, and wish for intimacy are paramount for marriage (Buss et al. 1990). Still, men in many traditional cultures generally say it is important that their wife should be a virgin, desires to be a housewife (i.e., not work outside the home), to have children, cook, and generally perform "female duties" such as cleaning and housekeeping. In terms of marital satisfaction, the evidence suggests there is not much difference if the marriage was arranged or chosen by the members of the couple.

Hopes by Gender

What is an ideal boy or girl? In the West, in previous generations it was quite common to encourage boys to be brave, "not to cry," and to "be tough," while girls were socialized to be "nice," to always try to please others, to be diligent, and to a degree serve others and to strive to do what other people wanted. This is changing rapidly, and there is a fading contrast between boys and girls, although those differences have not fully disappeared. In clinical work, one may see a father discouraging—or even slapping the hand of—a young boy who is attempting to play with a

doll or to play with a dollhouse. This is a strategy to teach "what should not be done" and to associate the activity with a negative outcome. In the United States, we often hear parents of male toddlers telling their child "don't cry" or "it is not hurting" or "you are tough, shake it off" when the little boy falls and gets mildly hurt. The idea of toughness and being brave for boys is widespread in many cultures: to mute emotional expressiveness and endure without protest. Often parents encourage the child who has fallen to get up by himself and protest when others "fuss too much around the boy."

Girls are often encouraged to play with dolls, to sit "properly," to wear dresses, and the like. In the Western world, more "masculine "behavior is tolerated in girls than "feminine behavior" is in boys.

It seems plausible that the definition of "masculinity" and "femininity" would have different meanings in various cultural groups, and not one description would fit all humanity (Weaver-Tower 2003). In an empirical study, parents in Canada and Iran were given a written vignette of regarding the behavior of a hypothetical girl to read. The little girl in the description acted very shy, she appeared afraid, never looked at adults in the eye, she hid behind her mother when approached by adults, and almost never talked at school. Adults were asked how worried they would be about such a girl and whether they thought she had any emotional problems. A majority of parents in the Canadian setting worried about the child as being excessively shy; however, in Iran, the opposite was true, where a majority of parents considered her entirely normal. This highlighted the cultural differences in expectations about how girls "should be." In the Iranian group, parents rather prefer that girls be self-effacing, shy, and somewhat fearful of the outside world (Doey et al. 2014). They should want to be "inside" rather than outside the house and feel that they need to be protected by others.

Parents in prior generations in Mexico encouraged little boys to "have fights" in front of the adults to see who was the bravest or the strongest, or the best at fighting. The parents celebrated the bravery of the children who were more likely to fight and punch the other children, at times ridiculing the weaker ones so as to encourage more toughness and bravery. This also has largely disappeared, but remnants persist in parental wishes for boys. Something similar is seen in many inner-city families in the United States, in which the mothers and fathers may feel it necessary for boys to be very tough; to fight back, in order not to be bullied; and to assert their place if need be through violence. It is feared that otherwise a child might not "survive" emotionally a very rough and tough environment.

In a recent study in New Zealand, researchers asked school principals what a "male role model" meant for young children. The findings suggested that a male role model meant "real men, heterosexual, rugby-playing tough men," i.e., a very traditional and stereotypical male model (Cushman 2008). There have been claims that the modern preponderance of women teachers in school has a "feminizing influence" that is not as suitable for boys. Also, several studies in the United States have shown that teachers treat girls and boys differently. Boys often are encouraged to not give up and persist trying to solve problems and are called on to answer questions more frequently than girls, particularly in the areas of mathematics and science. Girls are passed over more readily, and teachers do not encourage them as much to try to solve a problem in a different way or to "keep trying." The implicit message might be that girls are not so good at those disciplines nor should they be.

A related topic concerns parental dreams for the future of their children in terms of occupation according to gender stereotypes. In the industrialized world, there is still a perception that certain jobs are masculine or feminine. Would a father dream that his son become a nurse when he grows up? The same could be said of occupations such as teacher, designer, social worker, and others that are considered more "feminine." A similar prejudice exists for girls not to want to become soldiers, boxers, rugby players, construction workers, and the like. Although this is diminishing with the needs of industrialization for workers of any gender, there is still considerable segregation of genders in many occupations and

professions (Cross and Bagillhole 2002). Cultures do differ in what jobs are "masculine" or feminine. For instance in Southern Europe and Latin America, men are interested in occupations like waiting tables (which is considered a trade), as well as catering food and even child care (in Southern Europe) (Meadows 1996), which would not be the case in the United Kingdom. In several African countries, men have expressed worry that the "new masculinity" is equivalent to a feminization of men and advocate going back to a more "traditional African masculinity" which reinforces traditional role differences and the superiority and power of men over women (Morrell et al. 2012).

By contrast, in some European countries, the modern woman is one with "dual-track": aspirations of having a family, being a mother, and also having a career. Young women in the popular culture tend to be portrayed as assertive, self-assured, sporty, physically fit, and "non-maternal" (Wörshing 1999) which could be considered the "new ideal" for femininity.

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3 The Body of the Infant and the Parents, Parent–Child Interaction, and the Embodiment of Cultural Patterns: Commonalities and Differences

J. Martin Maldonado-Duran and Adam Goldberg

Fig. 3.1 Embodiment of the self. (Original artwork by Ana-Marcela Maldonado-Morales)

This chapter addresses a number of questions regarding the transmission of culturally based patterns of interaction and how infants and young children are socialized into specific action patterns in the frame of different cultures. In any given culture, people relate to each other in unique ways: there are differences in interpersonal space, when, where, and how touch occurs between individuals and what strategies parents use to instruct, contain, discipline, and socialize young children.

We examine the meanings of the body: for the expecting parents, in terms of the representations of a "pregnant body," and for infants, what is desirable or not, regarding body, intimacy, the embodiment of emotions, and its impact on the development of the child. We explore how cultural patterns are transmitted from one generation to the next and how children learn about physical closeness or interpersonal distance, relying on others (or not) and what these issues mean for the embodiment of cultural patterns, self-image, self-esteem, and feelings of competence.

An Ethological Perspective

Infants speak "the language of emotion," which is analogical, as opposed to the "digital language" which is based on the exchange of words and sentences. The analogical language depends on intuitive understanding mostly of emotionality.

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From the fetal stage, the baby is able to perceive sounds, evolving into recognition of familiar speech patterns—such as the mother's—by the time of birth. During the first 2 years of life, the infant will be exposed to a constant language "diet" of words and sentences that will lead to the acquisition and development of the spoken language from the adults around him or her. Beyond the verbal-semantic component of language, there are also elements of pragmatic language—nuanced connotations and occult/subtle intentions within spoken language—and nonverbal language, the gesticulation of the body, closely linked to the emotions, gestures with which parents communicate and which they also "read" in their infant. In this analogical communication, the baby perceives the emotional tone of the discourse of caregivers and what they convey "without words" but with their body. The language of emotions is the lingua franca between infants and parents, which is the means to communicate distress and containment; it includes crying, smiles, laughter, postures, body movements, and different neurological states of alertness in the infant. Normally, parents have an "intuitive understanding" to interpret the infant's bodily signals and emotions and respond accordingly, without the need for translations or training. Touch becomes one of the most important vehicles for this emotional communication between the parent and the infant (Stack 2010). Other vehicles include visual displays, auditory signals, smells, and pheromones among others (Wyatt 2014).

In the animal world, a complex system of signals to convey emotions and messages exists within species. Their behavior and appearance convey signals for dominance, submission, anger, fear, sexual arousal, etc. These messages are perceived by members of their species and often by members of other species. As an evolutionary feature indeed, interpreting those messages correctly can mean the difference between survival or not. These primary signals are called "honest signals" (Pentland 2008) and include showing fangs, lowering the head to show submission, presenting a sexual organ for sexual encounters, etc. (Plourde 2008). They may be reflexive or voluntary and can at times be purely autonomic (such as color change). The latter can also be included as mechanisms of "deception" in order to achieve other goals, like not to appear menacing, to go unnoticed, or to lure a possible prey; these are "dishonest signals." Given developmental immaturity, human infants do not employ such strategies. The human equivalent to these—the aforementioned pragmatic language, like hiding emotions, or pretending they do not feel what they indeed are feeling—appears later in life.

The Tactile Experience in Recently Born Mammals

In the bestiaries of the middle ages, it was common knowledge that lion cubs were born without any form and only after birth, through the licking from the parents, lion cubs acquired their lion features, limbs, ears, tail, etc. Also, it was thought that the cubs were born dead and the adult lion had to lick the nose for the newborns to be revived (Hassig 1999). Although we do not presently adhere to those beliefs, it is still clear that the licking of their offspring that many mammals practice may be critical for the immediate survival and development of the newborn. Rat studies have shown that if the pups are not licked in a certain "normal" way, these will not release certain hormones and other chemical messengers, and they will have difficulty thriving and urinating (Lenz and Sengelaub 2006). If the licking is substituted by brushing the back of the pups (within a "critical period" after birth) with a wet brush, the effect is similar to the normal licking (Levine 2001). This reflects the probable importance of tactile stimulation between human caregivers and infants—as a primer to attachment—which in some mammals is so important that it can mean the difference between growing or not growing, or developing a higher risk of morbidity, and experiencing very high stress (Jutapakdeegul et al. 2003) if the offspring is not touched. Besides licking, the rat mother spends much time feeding the pups, in close physical contact with them, grooming, and retrieving them if they move away.

In primates such as gorillas, chimpanzees, and others, the infant is in constant physical contact

with the mother (or other females) for extended periods of time and becomes very distressed if not in actual contact with them. This is thought to be an adaptive behavior to prevent predation and—in some species—to diminish the possibility of infanticide by adult males, which is a constant danger. What could be the representations of this or implications for human infants?

Touch During Pregnancy and the Postpartum

In most cultures pregnancy is considered a delicate period and one with considerable vulnerabilities. Many groups have developed rituals to diminish the stress in the mother, to help her be content, and to promote a good outcome for the future mother and the baby. These rituals involve diet, protections through amulets and magical means, and the avoidance of certain actions that are taboos. Some form of "therapeutic touch" has been developed in many cultures and has been used for centuries to help the expecting woman; usually this consists of some form of massage and applying specific healing or soothing substances, such as various ointments with attributed favorable effects on the woman and indirectly for the fetus.

In Mexico, Central America, and other American cultures, traditionally the woman was expected to participate in a ritualized touch called *sobada* (related to rub and soothe). These are most often performed by a specialized woman, and a specific technique is used, often with emphasis on the trunk and the limbs of the woman. The purpose of the abdominal massage is to "help the baby assume the right posture" and to soothe the expecting woman. The *sobada* is thought to have a protective effect, and at times it helps the anxieties of the expecting person as practiced by an "expert practitioner" who anticipates that things will go better after her ministrations. These ancestral strategies have been abandoned in many modern cultures as unnecessary at best or backward and cumbersome at worst. However, there is modern literature suggesting that the massage during pregnancy reduces the stress level of the expecting woman, increases the levels of endocannabinoids (which are associated with a relaxation response), and might be helpful in terms of the organization and mood of the newborn (Field et al. 2006; Moyer et al. 2004). It is well-known that higher levels of stress in the expecting mother have negative effects in her and on the child. In the latter, it is thought to be associated with diminished body weight, less organized behavior, excessive crying in infancy, and more disruptive behaviors in the preschool years (Huizink et al. 2004). Even though the traditional practice is often ignored, in some Western countries, the massage intervention has elicited recent interest and application (Stillerman 2008).

The massages are performed also after delivery to optimize recovery (Fuller and Jordan 1981). In the case of the Maya women of Yucatan, Mexico, the masseuse emphasizes manipulation of an area below the umbilicus of the woman, which is thought to be the center of the "human machinery," and then proceeds to massage the back, the legs, and other body parts.

Touch and Bonding in the Human Infant

From the embryological point of view, touch is the first sensory system to develop—from the ectoderm (the same as the whole nervous system), and later on, the tactile receptors are extended throughout all the surface of the skin, the largest organ in our body—accounting for around 16–18% of the body's weight (Montagu 1979). There is a higher concentrations of touch receptor in specific areas, such as the lips, fingertips, and others.

Several decades ago, Klaus and Kennel (Miller and Rodgers 2001) explored the importance of "allowing" mothers who had just delivered a baby in hospital settings to stay connected to their baby instead of the latter being taken to a separate room where the newborns were looked after by nurses. They suggested that the instinctive behaviors of mothers on the "first encounter" with the baby (now we would add the father) were important to promote empathic and compassionate maternal behavior and, to diminish the

stress in the baby, help the child to regulate body temperature and "find the breast" and be fed on demand (Mizuno et al. 2004). Experiments in Sweden revealed that if the baby is placed skin-to-skin contact, shortly after birth on the mother's abdomen, the infant was capable of "crawling" toward the breast and eventually finding one of them, not visually, but guided by smell (Varendi and Porter 2001). All of this reminds us of our ancestors and our animal nature, which at times is easy to ignore in the middle of all the technological advances, monitors, and computers that now attend the birth of a baby. Kennel and Klaus (Klaus and Kennel 1976; Kennell and McGrath 2005) recommended the institution of "rooming in" of mother and baby to allow these instinctual interactions to take place, undisrupted, and showed that even during the first year, the mother who had been permitted to do this undisturbed, tended to be more patient and more sensitive toward her baby than mothers who had been separated for considerable periods of time. This led to the institution of "baby-friendly" maternity units all over the world (Labbok 2012).

The First Encounter

Observing new mothers getting acquainted with the baby, in most cultures, there are some instinctive behaviors, such as holding the baby on the left side of the body by the vast majority of mothers (Huggenberger et al. 2009); smelling the baby (Kaitz et al. 1987), touching first the tips of the fingers, then the palms of the hands, and then the rest of the body (Trevathan 1981); and exploring carefully the face of the newborn and in general becoming familiar with its physical features. Later on, mothers (and fathers) are able to recognize, even when blindfolded, their baby and distinguish him or her from other newborns (Bader and Phillips 1999).

These "animalistic behaviors" such as touching, carrying, smelling, vocalizing to the baby, etc. seem to trigger a "bath of oxytocin" (Feldman et al. 2007) in the mother. This also is triggered by putting the baby to the breast, even if to express only colostrum. These actions also diminish the level of distress in the mother and promote the contraction of the postpartum uterus, and this leads to less bleeding and a sort of "falling in love" by the mother with her new baby. The father also falls in love, but his physiology has been less well-studied.

Many babies born in the United States in the past century, during the 1950s and 1960s, were born while the mother was unconscious, as she was totally anesthetized, which was a common medical recommendation. Physicians then also advised mothers to bottle-feed the infant with artificial formula, as it was thought to be "more scientific" to give a specified amount, and to not feed on demand but with a schedule. All of this was thought to be helpful for the child to develop a routine and a schedule and now has been largely superseded, although still many parents prefer to adhere to a schedule for feeding, napping, etc.

A further consequence of skin-to-skin contact between the baby and the mother is an analgesic effect (Gray at al. 2000). This has been shown in studies of procedures involving some pain to the baby, who shows a much less intense reaction when he or she is in contact with the mother, compared with lying on a crib.

Attachment and Touch

There is an extensive literature in attachment theory, which emphasizes the role of emotional security, parental sensitivity, physical proximity, and physical contact in very early childhood as a precondition to developing a feeling of security in the attachment relationship to a few caregivers. This literature will not be reviewed here, but in some Western countries, there is a new movement toward "attachment-based parenting" in which parents take an active role in responding to their child and assisting in the regulation of emotions and diminishing distress, to promote mentalization and empathy. This often includes strategies that involve touching, skin-to-skin contact between the baby and a caregiver, and soothing the child and helping to reduce his or her distress by touch, holding, carrying, etc. Something similar has been developed to help foster parents to be emotionally responsive to foster children in order to promote a sort of reha-

bilitation from emotional and physical deprivation and abuse; some of this includes physical proximity, responsiveness to the child, and human contact to reduce distress and anxiety (Dozier 2005). It has even been suggested that there might be a greater tendency to depression later on, during adulthood, if a child is rarely touched during infancy (Takeuchi et al. 2010). There is little research on the biochemical manifestations of touch in the infant and the caregiver, but the evidence from the attachment literature suggests that touch can be a powerful reinforcer of attachment security, in the sense that the mother, father, or other caregiver can use the touch to diminish the distress in the child and promote the sensation of being safe, and it has a calming effect. Other vehicles such as the mother's or father's voice, or visualizing them, can be also sources of reassurance particularly as the infant is a few months old.

The Infant and Young Child's Experience of Being Touched and the Parental Response

In other chapters we have reviewed how mothers from traditional societies spend a lot more time in physical contact with their babies, through carrying and taking the baby on devices on their body even during work hours (for instance in the field, while the baby is on the mother's back). The baby is fed on demand, and there is an intimate contact between the bodies. The mothers often learn to recognize the baby's signals of hunger and the need to urinate or defecate by "reading the body" of the baby, its movements, tension, and other signals.

Two additional issues are explored, as they are common in many cultures: daily or ritualized massage as a part of the normal caregiving regime and also the types of "parent–child games" which often involve physical contact with the baby involving hands, legs, arms, the trunk, etc.; both parents and infants take pleasure in these transactions, which also may have implications later on in motor development (Jamain-Rabin and Wornham 1993), body schema, and the capacity to regulate emotions, as well as attachment.

In many traditional cultures, a ritualized massage is given to the baby to promote his or her development and strength, as in the South India (Stork 1986) and other parts of that country, as well as in Latin America. In some African cultures, the massage performed with specific oils is also thought to have a protective function against evil spirits, and it is also thought to eliminate impurities. In the Middle East and India, a sort of "makeup" is applied to the baby, as a form of decoration, to beautify the child, and thus foster that he or she will decide to stay in this world, as well as to celebrate the baby's life.

Many parent–infant games are accompanied by rhymes and songs and are practiced in many societies, but perhaps they are tending to disappear with the advent of more "substitutes" for caregiving and electronic devices that occupy so much attention from parents and provide a repetitive music for the infant, such as electronic devices.

Traditionally among the Gujarati population in India, the postpartum mother is thought to be in an impure state and has to be carefully monitored for at least 20 days. She starts producing milk for the baby (which transmits wisdom from ancestors and is considered pure). At the same time, she is in an impure state in the lower part of the body. She needs to receive a massage from her mother or another older woman in order to recover her strength, and also she or a "professional massage" woman will perform daily ritualized massages on the baby (Spiro 2007), to cleanse the child who is at risk from the impurities of the mother, to purify the body and to make the baby strong. The massage can be quite intense for the observer but essential for those purposes.

In other traditional cultures, massaging the baby is practiced as a part of the daily routine, for instance in some cultures in West Africa (Jamain-Rabin and Wornham 1993). Observing women from West Africa, the researchers noted that the baby was exposed to daily massage and that rather strenuous movements, stretches, and vigorous massage were performed on the baby.

In other countries in South Asia, as in Nepal, the mother is expected to perform massages every day. The massage has the function of making the child brave and fearless; also it is thought to

strengthen the bones, to promote weight gain, and to improve movement coordination (Reissland and Burghard 1987). In essence the mother is "shaping the child's body" through the massage. The baby may be rubbed with an ointment (*ubtan*) that will lighten the skin color, making thus the child more beautiful. A special mixture may be placed over the fontanelle in order to strengthen it. A technique to promote fearlessness may involve holding the baby from the neck and dangling back and forth the rest of the body.

Tactile Interactions and Their Effect on Young Children

Cultural groups differ considerably in their nonverbal interactions and communications in many respects, including touch. Children learn by imitating the "codes" of interpersonal communication, obviously through verbal language but also through body language, movements, postures, gestures, and interpersonal touch (Eckerman and Whitehead 1999). The study of nonverbal communication takes into account factors like interpersonal distance. There are vast differences in how close adults get to each other in normal communication, be it within their family, in the workplace, or in social situations, an aspect that is called "proxemics." This has been studied mostly in Westernized societies. One example is the interpersonal distance in Germany or Britain, which is is generally much larger than between people in Italy or Spain. Another dimension of nonverbal communication is "haptics"—the frequency and spontaneity with which people touch each other in their everyday interactions. Here again, some cultures seem to foster more spontaneous touch during conversation and play than others (McDaniel and Anderson 1998). The quality of the touch and the "meta-rules" associated with it also are determined by culture and context. There is some evidence that in the Middle East or South America, there is a higher frequency of touch between people than in some North European countries.

There are societies that are more oriented toward hierarchical social status and showing signs of prestige and reputation of power through signs of the body. The nonverbal language differs to show, for instance, triumph or dominance (Matsumoto et al. 2014). These signs are observed and then acquired, incorporated or embodied by children who learn to display those signals conveying different meanings. For instance, it has been shown that in preschools, children want to sit "next to" the more dominant or higher status members of the classroom; this applies to boys and girls (Howley 2003). Also, the children tend to look toward the dominant members of the class, and they also attempt to gain their visual approval and imitate their actions. This direct "ethological dominance" is modified by culture, as social cooperation may be taught and praised. Commonly, in preschools in Japan, children are encouraged from very early on to cooperate and help each other (Burdelski 2010) and do many things in teams, as opposed to individually. In those preschools, social status is also gained by showing more cooperation and social helpfulness.

Patterns of social interaction, gestures, and movements that connote meanings are "embodied" by young children and certainly by the socializing experience in group settings such as child care centers or preschools. As noted, some patterns are encouraged by adults, as in societies where prestige and high social status are valued, and in these "positive politeness" tends to be emphasized by parents and teachers. This is done by showing interest in others, finding common ground with others, and minimizing disagreement with peers. There are other cultures, that are more "other-oriented" in which individual prestige and success have to be shown in a different way. Often in these societies, there is a "negative politeness" in which children learn to show deference to others; emphasize honorifics (recognize those with higher social status and show deference), being indirect; and minimize imposition (Burdelski 2010). All of these behaviors are manifested by different styles of bodily interactions and gestures, as well as with spoken language (words, tones, rhythm of speech, etc.). Often, for instance, young women in Japan show politeness by talking in a high-pitched voice (Loveday 1981). Observing adults interacting with each

other, children learn “politeness formulas” which are recognized in each culture. In more individualistic societies, adults prefer to use original expressions to show politeness, while in cultures with greater individual interdependence, adherence to formulaic expressions seems to be preferred to show politeness. These formulas involve words but also facial expression and body movements.

In American preschools it is common for teachers to teach children to say “no” or “stop” or ask for help when they do not want to share a toy or when another child takes it. In a very different culture, as in Japan, teachers may encourage children to share their toy if another boy wants it and to show politeness in lending it. This issue is often a question in families in which a younger child takes toys from an older sibling. In some cultures, children are socialized to “stand their ground” and in others to “share with a smaller child.” These differences in approach are easily misunderstood in the interaction between teachers and parents or between therapists and families from different backgrounds. A similar sequence could be observed when a small child requests to join a game.

In some cultural groups, teachers may “sculpt the body” of the child to teach certain behavioral patterns, like assist young children to bow in the presence of an authority figure, to greet, etc. In Japan, for instance, it is considered rude to pass some desired object with just one hand, and even a pencil has to be given with both hands, in a polite gesture. Teachers spend time modeling and reinforcing those “patterns of embodiment” that will help the child function socially and in which kindness is intensely reinforced.

In the United States and other industrialized countries like the United Kingdom (Piper and Stronach 2008), Australia, or Canada, there are considerable restrictions by attendants in preschool and child care settings about “touching children.” There are regulations about what is considered acceptable, like touching the children when there are other staff witnesses, etc. This is based on the fears of accusations of sexual molestation, which is a pervasive concern.

Even young children are discouraged from touching each other. The motto “keeping our hands to ourselves” is heard in many preschools in the United States (Field 1999). This is hard to achieve in preschools and nurseries, as young children exhibit the primate behavior of “play fighting” and hug each other, seek proximity when they are distressed, etc. This now extends in the United States even to some policies in hospital settings in which adult staff are discouraged from touching each other, as there is also a “no-touch policy.”

Children who might benefit from the stress-reducing effect of touch, or who are used to those patterns of interaction with their families, may feel “lost” in a child care or preschool setting where this is now allowed. In our clinical work, we have encountered children who feel unhappy and criticized because they “hug too much” or touch other children, who are not used to such interactions. The teachers also may feel inhibited from hugging or reassuring a child who is missing his or her mother at the beginning of school, etc., and the general emphasis is on “soothing oneself” without intervention from another person. Something similar can be said of children who are very angry, enraged, or oppositional, in which gentle touch by the teacher might help the child to regain control or calm, but the teachers request that the child accomplish this by him or herself. Often, in those same settings, teachers issue “long-distance commands” verbally to children to do something, or stop doing something untoward, but they do not use touch and calming strategies to redirect their attention or help the child to focus elsewhere, and it is expected, sometimes with very little success, that the child control himself on his own devices. Field (1999) has suggested that one of the factors that explains a higher rate of aggression between children might be touch deprivation, in general, and specifically in schools. The calming and appeasing function of touch may be lost due to concerns about litigation or accusations. Field has also suggested (Field 2002) that touch deprivation may be a factor in increased aggression among adolescents, due to their current deprivation but also to the possible deprivation of touch from infancy. Several studies have compared the frequency of interpersonal touch among preschoolers from different backgrounds. Puerto Rican and

other Latin American children, as well as French and Italian children, touch each other more frequently than Caucasian children in the United States.

By contrast, in Sweden there is a long tradition of using massage for adults in various circumstances. Several studies have shown that practicing massage for preschool children tends to reduce the frequency of aggression between them (Von Knorring et al. 2008), and it is practiced in some preschools, sometimes from one child to another (Kagan and Hallmark 2001). This is hypothesized to lead to stress reduction and increased levels of oxytocin in the children.

Kangaroo Care

Kangaroo care was born out of sheer necessity and in a context of poverty. It represents perhaps a "leap of faith" on the part of the medical establishment to look at the traditional practices in their surroundings and "daring to implement them" even when it seems like going backward. It was in Colombia (Instituto Materno Infantil de Santa Fe de Bogota) in a hospital where there were not enough incubators to deal with the high number of premature babies that had to be cared for. As the incubators already had accommodated more than one baby per unit, the staff saw the need to try something else (Rey and Martinez 1983). They resorted to placing the premature babies, after a certain postpartum age, around 32 weeks, directly under the mother's shirt and in "skin-to-skin" contact with her chest. The thinking was that the mother's body would help the premature baby to not get cold and at least temporarily, while an incubator became available, and this might allow the baby to thrive. The mothers seemed to be quite satisfied with the experience, as they could become involved directly in taking care of their baby, quite in contrast with the regular experience in most neonatal intensive care units at the time, in which mothers were only permitted to "visit" for 2 hours a day. They had to trust the care of their baby to "strangers" (nursing staff) and had no control or involvement in their infant's life except as visitors. Also, they were at times seen rather as an intrusion in the routine of the nursing staff that was conducting the "real medical care" of the baby.

The skin to skin (kangaroo) contact continued and was evaluated as to its possible benefits. It proved to have multiple benefits: it diminished the number of days the babies stayed in the hospital, and the infants tended to gain weight faster. The kangaroo care also promoted breastfeeding and diminished the frequency of infections and other complications; it proved to be better than "care as usual" in the incubator. The procedure was implemented readily in cultures in which people tend to have a community orientation, like Colombia (Conde-Agudelo et al. 2012), and then extended to other Latin-American countries, such as Guatemala and Mexico, among many others.

There were other benefits: mothers would be together in a group setting, talking among themselves, and getting to know each other. They often gave mutual psychosocial support, encouragement, and could discuss some of their problems in a sort of informal group therapy format. In addition to the reduction in infections and length of hospital stay, there was also a reduction in the rate of abandonment of infants in the hospital. This was theorized to be related to the "bonding" and intimate relationship fostered by the skin-to-skin contact between the mother and her baby. Later on, the practice was also implemented with fathers, when they were available (Lundqvist et al, 2007). Given the benefits of the method, it has been extended throughout the world, although different hospitals may or may not adopt it for multiple reasons.

Massage Interventions for Infants and Caregivers

A number of researchers interested in mental health approximately three decades ago became interested in the caregiving strategies they had observed in several regions of Africa, Asia, and South America, which seemed to lead to babies that appeared calmer and less dysregulated than infants who had spent a lot of time in child care settings at that time and who had received the routine "more distant" care in the United States. One of the pioneers in this area was Tiffany Field,

who founded the Touch Institute in Miami; she and her research group conducted a number of studies on the possible benefits of touch and massage. Following on her work, numerous centers then have also studied the effects of touch and massage interventions and have proven a number of benefits for babies and older children.

What turned out to be surprising and reassuring is that the massage interventions also benefit the adults that "give the massage" and not only the ones who receives it. Field and others have demonstrated a beneficial effect on stress, stress hormones, and also in levels of depression in mothers who practice massage in comparison with those who do not. The same has been observed with fathers who practice the massages, as well as with elderly people, when they are given the opportunity to practice it and who often are themselves deprived of touch (Field et al. 1998).

The studies on the effect of massage have been extended to young children, preschoolers, school-aged children, adolescents, mothers and fathers, as well as the elderly. The evidence indicates that it benefits the high levels of stress in young children who are exposed to anxiety-provoking circumstances. Massage is often used to try to calm infants who exhibit sensory integration difficulties, such as tactile defensiveness and hypersensitivity in multiple sensory channels, and who then can relax and tolerate stimulation, make the transition to sleep, and modulate their discontent.

The massage has shown benefits in reducing dysregulated behavior, aggression, as well as diminishing anxiety, in preschool and school-aged children. It helps improve conditions like asthma and may assist in a better functioning of the immune system.

Playful Interactions in Early Childhood

Parents intuitively imitate infants and mark their emotions and promote their emotional and motor development through a number of games and in everyday interactions; thus parents reinforce certain behaviors and discourage others, in a way that is spontaneous (Kwon et al. 2013) unconscious, and intuitive. Caregivers unwittingly transmit from one generation to another certain gestures, ways of moving, of showing discontent, happiness, fear, etc. Some of the expressions, particularly of facial expression of emotion, might be universal, and some might be more specific to certain cultural groups.

The observation of toddlers in different cultures shows that they engage each other in games of imitation of actions and gestures, almost as if rehearsing "how to move," how to play, etc. (Eckerman and Whitehead 1999). This may have to do with the evolution of "mirror neurons" which exist in many animals, and in humans they lead to innate and involuntary reaction to observing others move, enact, and react (Heyes 2010).

In many cultures, fathers play with their young boys or girls differently. In many, there is more physical interaction and play fighting between fathers and boys, while the transactions with girls are less physically intense. The responsiveness to the young child's cues in fathers is related to the perception of what a father does but also to individual factors, such as the way the father grew up, how he has learned to behave "as a father," and his level of stress, tiredness, etc. as with mother; oxytocin seems to make fathers more sensitive to the cues of their young child (Naber et al. 2010). Other factors are testosterone, cortisol, vasopressin, and prolactin, which in mammals seem to be mediators of the "parenting behavior" toward the offspring (Feldman and Bakermans-Kranenburg 2017).

The Infant's Body and Inter-corporeity

By the time the human infant is born, there are already in operation "imitation mechanisms' for gestures and actions that are thought to be "wired in" the brain and allow the newborn to automatically imitate the gestures of an adult who makes a sad face and a surprised face and who shows his tongue; and the newborn will tend to pattern his or her facial gestures after what is being presented, of course within certain limits. There is even a mechanism that is called "intermodal per-

ception" by which the newborn can "transfer" what he is seeing into another sensory channel. For instance, the baby who is presented with the image of a triangle can "identify" a nipple with triangular shape and distinguish from other nipples with different shapes.

A few decades ago, Gallese demonstrated the existence of "mirror neurons" which led to much interest in the field of perception and learning (Gallese 2002; Heyes 2010). It seems that humans innately experience the activation of certain areas of the brain that "mirror" actions that they are observing in another person (Keyers, 2009). If one were to see someone riding a bicycle, the corresponding neurons associated with pedaling would be activated in the brain of the observer. This phenomenon has been associated with the concept of "inter-corporeity" as proposed by Merleau-Ponty much earlier than Gallese's discoveries (Lupton 2012). Merleau-Ponty suggested that the body of another person has a distinct effect on the human who is in front of that person (Merleau-Ponty 1962). There would be a different "effect" for instance if a small and fragile person were in front of a very strong, tall, and vigorous person, as compared with the effect of a similarly small and thin one. This effect is unconscious—a "reaction" that one experiences when one is in front of another person, their movements, their voice, their gaze, etc.

One of the implications of this is that the infant is a "perceptual apparatus" that is constantly exposed to the interactions with a few caregivers and their actions, gestures, voices, etc. This may lead to what one might call the "embodiment of the self" which is constructed from the continued experiences with other people.

It has been shown that when 4-month-old infants are interacting constantly with a depressed mother, the infants themselves "look depressed." This might be related to the diminished experience of joy and playfulness in the interaction with a depressed mother, who may be more "flat" in her emotions, withdrawn, and less responsive than a mother who enjoys more being with the baby and engages in mutual stimulation. Also, the infant of a very active father, who provides intense stimulation, lots of "hands-on" games with the baby, throwing him or her on the air, dancing, etc., will have a different somatic experience and exposure to sensations compared with an infant whose father is distant, hardly interacting with the child, and barely touches him or her.

In the cultural plane, different social groups will lead to a different "embodiment of experience" according to social codes, from the games and actions that are thought normative in each culture. For instance, as we described, the experience of the infant massage among the Gujarati, when observed by a person from a different culture, may seem almost extreme in the handling of the baby, who will be held from the head, dangling from the neck, squeezed vigorously by the masseuse, and will have air blown in the nose in order to "clean" those areas. Also, what are considered "normal maternal behaviors" may be very different among social groups, as well as the infant games between parents and infants.

An additional source of "inter-corporeal" input in many cultures is the constant presence of other children in the surroundings of the infant. In many societies older siblings may provide a significant amount of care and play interactions with the baby. When there are many cousins and other young children in the neighborhood, there are also many "bouts of imitative behavior" in which toddlers imitate each other in an intuitive fashion (Eckerman and Whitehead 1999). These imitation games are spontaneous and not staged. They are likely to occur also in child care centers in Westernized countries where infants may spend many hours in nonparental infant or toddler care. In these imitative bouts of interaction between young children, a boy throws a ball, and the one next to him also throws a ball, one jumps, and the next one also jumps. This tends to occur around 20 months of age and is related to the mirror neurons and the embodiment of the social experience in oneself. The activities that are permitted are dependent on culture and what is considered normative or adequate for "boys or girls" or for children of a certain age. In many cultures, traditional and Westernized girls are not permitted to be "too rambunctious" and are often rewarded for being quiet, sitting around, and

playing with other girls. Boys may be encouraged to be "brave" and daring, and some might be admonished or ashamed for "being afraid" of jumping from a height or getting inside a swing. These patterns, while clearly modeled by culture, have not been studied abundantly nor the effects on the development of the self in the long term.

There is much to be learned about the influence of cultures and social practices on touch and interpersonal contact, also on the effect of such contact on emotional and neurophysiological development, the regulation of stress and the long-term effects of touch deprivation, aversive touch, or reassuring containment through tactile interactions.

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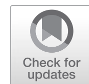

4 Prejudice, Discrimination, and Stereotyping

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Introduction

In everyday life, we all encounter instances of prejudice, stereotypes, and racism. This occurs perhaps in most countries where there are different groups of people, of diverse ethnicity, origin, beliefs, appearance, habits and practices, etc. These will be moments where a person would be on the receiving end, or the person might incite an incident of this nature, where bigotry or discrimination is in action, even if doing so unwittingly or passively.

As human beings, we form categories to make sense of the world: the sky is blue, the grass is green, the stove is hot, and the ice is cold. How we perceive ourselves comes from what we have been directly, and indirectly, taught by our families, friends, media, and popular culture. Prejudice is a judgment of that is based in opinion rather than fact (Tatum 1997). Generally, the prejudice leads to dislike or condemnation of an "out group." The prejudice develops from stereotypes, limited or lack of exposure, or interactions with people outside of our daily lives. This prejudicial belief can be blatant or subtle (Pettigrew and Meertens 1995). The first one is direct and conscious, applied based on a preestablished belief about "other people" and the conviction of knowledge of how they are, what they believe, what they do, etc. In the subtle form, there is a distance and a wish to not know, avoiding getting in contact, and keeping away from "the other people." In the empirical work of Pettigrew and Meertens on racism and prejudice, "blatant prejudice" is operationally defined with two dimensions: perceived threat from the rejection of the outgroup and opposition to intimate contact with out-group members. The "subtle prejudice" has been defined with three dimensions: defense of traditional values, exaggeration of cultural difference, and denial of positive emotional responses to the out group.

The dislike often is not based even on direct contact with the despised "group of others," and there is some evidence that direct contact and exposure to "them" may lead to diminished prejudice (Hamberger and Hewston 1997).

Additionally, many people are unaware of the beliefs they hold, having obtained them as a persistent, and unfortunate, consequence of living in a society embedded with system racism. This is because we are each born into a specific set of *social identities* related to the categories of difference mentioned above, and these

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social identities predispose us to unequal *roles* in the dynamic system of oppression. We come to see the diminished status or devaluation of some social groups as acceptable, natural, and unavoidable.

We are then socialized by powerful sources in our worlds to play the roles prescribed by an inequitable social system. This socialization process is *pervasive* (coming from all sides and sources), *consistent* (patterned and predictable), *circular* (self-supporting), *self-perpetuating* (interdependent), and often *invisible* (unconscious and unnamed) (Harro 2000, p. 15).

How individuals perceive race and racism can influence how they understand their identity, their actions, and their views on society. In this chapter, we provide an overview of these topics, rather than an in-depth study. It is important to be aware of these concepts when working with all people in a professional setting. Failing to acknowledge how our own privilege, or perceived power, affects how our interactions with clients/ patients can negatively impact the effectiveness of the treatment we deliver.

This chapter will view “cultures” in the context of groups that live together in the United States although the information is applicable in any context of an industrialized country when one deals with a “minority” or “underprivileged” client. According to the Office of Immigration Statistics of the Department for Homeland Security in 2015, over one million individuals from other countries were granted lawful permanent residence in the United States (DHS.gov). Individuals from over 70 countries were included in this measurement; the five countries with the most immigrants were Mexico, China, India, the Philippines, and Cuba (DHS.gov). Although this represents a very diverse group of people, this measurement only includes those granted permanent residence and excludes those already residing in the country, naturalized citizens, and undocumented immigrants. These are people from countries all over the world, with their own language, customs, religions, and belief systems living together in one country, a country that was inhabited by Indigenous groups, then colonized by European immigrants. The United States, like many European countries, has become a combination of cultures, beliefs, and languages; any group faces many social injustices.

It is vital for a clinician to recognize and self-reflect on thoughts, actions, and beliefs in regard to people who not only do not share their same privilege identities but also who do not share their own identities. A clinician might endeavor to be able and willing to work with clients from any background and situation. For example, people with mental disabilities face a great deal of stigma, not only from society but also from themselves; consequently, a negative or pessimistic attitude toward these clients from a social worker or mental health professional can create further stigma and augment a negative perception of themselves as well as of receiving care (Harrison and Gill 2010). To avoid this, clinicians might try to be particularly conscious of how their own beliefs, perceptions, and identities affect how they view other people and society as a whole. Clinicians often do not like to face and come to terms with their own privileges and discover they have oppressed another group of people; however, without this revelation and knowledge, change cannot happen, and oppression continues.

Individual, Institutional, and Structural Discrimination

People use schemas to evaluate themselves and the social roles, social groups, social events, and social actors they encounter, in a process known as social cognition. The categories into which they divide up the social world may change over time and evolve with experience, but among mature human beings, they always exist, and people always fall back on them when they interpret objects, events, people, and situations. Humans beings are programmed psychologically to categorize the people they encounter and to use these categories to make social judgements (Massey 2009).

The need to make sense of the world through categorization occurs naturally to humans. Inherently, there is nothing unjust about

categorizing people; it is when these categorizations begin to ignore, exclude, or create negative action against those in another "category" that they become discrimination. Discrimination, or the unjust or prejudicial treatment of different categories of people, especially on the grounds of race, age, or sex, is how people are excluded from society. The concept of a dominant group and a minority group indicates the amount of social power or the lack of power held by that group. In the United States, the dominant power has been historically held by people of White European heritage and primarily affluent white males (Pincus 1996). This inequality in power has led to hundreds of years of oppression and racism. In recent years, in an attempt to move toward an equitable racist society, a "color-blind" mentality was developed, as a way to not "see" racism.

The "color-blind" mentality that the United States has largely adopted minimizes the pervasive disparities in access to services due to race, ethnicity, and socioeconomic status, and a "form of lacking awareness in diversity and is associated with lower levels of cultural sensitivity" (Wang et al. 2014, p. 213). The United States, like many other countries in the world, has systems of inequality, systemic oppression, and discrimination. In adopting a "color-blind" ideology, there is the implication that society does not see race. This practice of being aware of race but choosing not to acknowledge its presence makes it nearly impossible to hold organizations or society as a whole accountable for racist systems and conventions (Welton et al. 2015). The United States, like other countries, has experienced colonization, slavery, and systematic oppression of people. Out of this oppression came the concept of race and racism, to categorize people and create a structure of power.

Racism creates a racial structure—a network of social relations at social, political, economic, and ideological levels that shapes the life chances of the various races. This structure is responsible for the production and reproduction of systemic racial advantages for some (the dominant racial group) and disadvantages for others (the subordinated races) creating a sense of "us" versus "them" (Bonilla-Silva 2015, p. 1360).

Seeing all people in a society as different yet equal can create more systemic tension. All humans arrive at each interaction with their own thoughts, wants, needs, and prejudices, which can then in turn lead to behavior driven by ignorance and fear and lead to discrimination.

Sociologist Fred Pincus (1996) explains the three types of discrimination: individual, institutional, and structural.

> Individual and institutional discrimination refer to actions and or policies that are intended to have a differential impact on minorities and women. Structural discrimination on the other hand, refers to policies that are race or gender neutral in intent but that have negative effects on women, minorities, or both. (p. 1)

Examples of these types of discrimination can be seen in everyday life in the United States. Individual discrimination is seen through the actions of individuals, or small groups, acting against other individuals due to a particular belief. An example may be a White man who will not purchase items from a store owned by a Muslim family.

Unlike individual discrimination, institutional discrimination is discriminatory behavior embedded in important social institutions. It is usually carried out by a dominant group against minority groups because the dominant groups control social institutions (Pincus 1996). Examples can be seen in US history in school segregation, Jim Crow laws, and how communities are created and who can access them. Because of its nature and the fact that it is embedded into the law, institutional discrimination is often difficult for dominant groups to see or accept. White people may be more willing to acknowledge instances of institutional discrimination carried out against African Americans or other minorities in the past, since in the present it has been "resolved," such as the case of school segregation and voting rights. Similarly, most men accept that women should be able to vote, now that a century has passed since they won this right. It can be easy for those in the dominant group to assume that the institutional discrimination of the past has been resolved. Given that they are not directly experiencing racism,

they may overlook acts of racism and discrimination that may be happening around them. This privileged lens can also convince them that they are not racist, as they would not overtly act in a "racist" manner, but still their behavior is influenced by their examined beliefs (Dovidio et al. 2008, Gee et al. 2016). Systems are difficult to change, and thus individuals continue to be socialized to believe certain things about other people different from themselves. Institutional discrimination can often be uncovered by asking oneself questions such as "Where are new buildings being built? Who is able to access home loans and other types of banking benefits? Who has access to which communities (such as public transportation, home price, affordable house, etc.)? Are those who hold positions of power in a community representative of those living there? How are laws disproportionately affecting certain communities?"

Structural discrimination is defined by Pincus (1996) as being different from institutional discrimination in that it lacks intent. Angermeyer et al. (2014) define structural discrimination as "institutional practices and policies that work to the disadvantage of the stigmatized group, even in the absence of individual discrimination" (p. 61) and distinguish between intended and unintended discrimination.

> Intended structural discrimination encompasses rules, policies, and procedures of private and public institutions that purposefully limit rights and opportunities of people…unintended structural discrimination includes major institutions' policies that are not intended to discriminate but whose consequences nevertheless hinder the options of people. (Angermeyer et al. 2014, p. 61)

Although Pincus and Angermeyer, Matschinger, Link, and Schomerus have some difference in distinctions of discrimination, the fundamental idea is similar that discrimination can occur from an individual interaction to institutional systems.

The following are vignettes to further explore the incidents of discrimination in the United States. Discrimination and racism can be both overt and covert/subtle. This example could occur with an individual from several countries of origin, or ethnic/racial group.

Omar is an immigrant from El Salvador who has recently arrived in a Midwestern city in the United States. He is a high school graduate in El Salvador and is able to read and write in Spanish; his English, however, is weak. His skin is fairly dark, but he would not consider himself Black. Although he has work authorization from the Department of Homeland Security, Omar finds work in landscaping alongside mostly undocumented Latinos. In the United States, Omar encounters many people that are of all different races, languages, and cultures. He finds it very different than his home in El Salvador, where everyone he knew was mestizo *and shared Salvadoran culture. Omar tries to rent an apartment, and when he finds that many landlords do not return his calls, he decides to live in apartment with other men with whom he works. The men caution him to avoid "los morenos" (African Americans) because several of them have been robbed at gunpoint in front of the store where they cash their paychecks by African Americans.*

As a member of a minority group, it is likely that Omar will experience discrimination in his new home that he may not have experienced in El Salvador. It is also likely that as he assimilates into US culture, he will create new categories in his mind that might or might not lead to individual discrimination. Omar feels discriminated against when landlords do not respond to inquiries. The individual landlords are discriminating against Omar, due to his accent or his name. Omar begins to identify and feel a part of the group of Latinos in the United States and in turn also begins to categorize people in a similar way. These categories lead to discrimination being carried out against African Americans, thus perpetuating more stereotypes and racism.

It is also important to note that because one member of one minority is being discriminated by the dominant group does not mean that individual will not also discriminate another member of another minority group, as seen above.

At times discrimination can be observed in a quieter manner.

Lourdes enjoys shopping and finds that this how she likes to release stress. Lourdes grew up in the United States, but her parents immigrated

from the Philippines before Lourdes was born. Lourdes recently received a promotion at her company and decided to reward herself with a new wardrobe from a fancy boutique shop in town. Feeling confident and happy in her accomplishments, Lourdes walked into the boutique, without really noticing that she was the only woman of color in the shop. The saleswomen were White, as were the customers. After a few moments of looking at clothes and shoes, Lourdes noticed that no one offered her any help or asked if she needed to see an item. Lourdes saw a few White women come in after her, and they were greeted warmly and asked if they needed help. As Lourdes walked around the shop, she noticed that the saleswomen were following her, without speaking to her or offering help. When Lourdes asked to see a pair of shoes, the saleswoman was short and curt in her responses and treated her differently than the other customers. Lourdes walked out of the shop empty-handed, hurt, and embarrassed but not quite sure why she should feel embarrassment, causing her to also feel angry.

Lourdes was treated as though she was doing something wrong by being in an upscale shop. Although the saleswomen did not say the words that Lourdes was not welcome there, Lourdes was made to feel this way through the sales staff actions of following her and not offering their assistance. One cannot say whether the shop workers were aware of their behaviors, but ultimately, they were discriminating against Lourdes because of the way she looked. Their actions indicate their assumptions that because Lourdes is an ethnic minority, she could not afford what was in their shop and might even steal, thus she needed to be watched, but any further effort would be a waste of their time. As previously mentioned, institutions can perpetuate and reinforce discrimination, racism, and prejudice. For example, when a bank has two applicants for a loan, who, on paper, seem the same—the same income, credit score, etc. the African-American applicant is denied, while the White one is approved. Institutions perpetuate discrimination when service is denied to a Muslim family at a restaurant or an individual is not allowed to vote because she does not have the "correct" form of identification. There are countless examples of individual, institutional, and structural discrimination throughout history and currently.

In the present, some people feel as though society is moving toward a "post-racial" world, in which racism and discrimination are issues of the past. As previously mentioned, changes in laws and regulations to be more "inclusive" and discourage discrimination against ethnic minorities and women are seen as proof of this "post-racial" world. Some individuals cite the election of President Barack Obama in 2008, the first African-American president to be elected in the United States, as a symbol of moving toward a post-racial society.

> A focus on post-racial ideology identifies hegemonic ideas and systems of representation that shape the means through which racism itself becomes normalized and concealed, reinforced and reproduced every day in interactions and institutions. Post-racial ideology circulates in situations where various degrees of race- and/or color-blindness, denial of racism and colonialism, and racist sentiment endure alongside persistent, implicit race-consciousness in peoples' minds and in state policy. Belonging and inclusion become fraught as the avoidance of racial difference in discourse or policy sustains rather than eradicates coloniality… the articulation and re-articulation of race to hierarchies of value/worthlessness, acceptability/disposability…Rather than constituting a contradiction (i.e. race does not exist but has effects and affects), elision is a key means by which racism operates through the absence of intention clearly linked to the concept of 'race'. The outcome is an apparent disappearance of race without the disappearance of its histories, meanings, and cumulative effects. When deployed as a strategy of power, post-racial ideology seeks to depoliticize race, racism, and difference in ways that demobilize anti-racist politics, substantive cultural recognition, and material redistribution. (Emboaba Da Costa 2016, p. 477)

In an era of global movement, individuals and groups of people who perhaps would have had little interaction 100 years ago are currently able to live side by side. In having a variety of ethnicities, races, and cultures living together, the differences between people are perhaps more apparent but also as time goes on, perhaps more commonplace, leaving less room for overt racism

but failing to renounce discrimination or prejudice.

Beyond Cultural Competency: Working Within a Transcultural Framework in a US Context

From the concepts of color-blindness and a post-racial society came the idea of cultural competence. The idea of cultural competence is not like the color-blind concept of not seeing difference but rather requires recognizing differences between individual and using these differences to inform interactions and "working relationships that supersede cultural differences" (Beach et al. 2005). In theory, it can be helpful for one to have some knowledge about another person when having an interaction with them, particularly a professional interaction, but this does not guarantee the absence of prejudice, discrimination, or racism.

Some concerns about cultural competence arise from how individuals learn about cultures and customs and that it could possibly promote more stereotypes, biases, and discrimination (Beach et al. 2005). Stereotypes and biases could be increased when speaking about large groups of people as one, rather than seeing people as human beings and not only as part of one group. Describing the practices of "one group" likely does not accurately describe the practices of all group members. For example, stating that "all Catholics," or "all Asians," believe or do something can create stereotypes, which may be partially based in fact but cannot be verified for all group members.

Perception of identity is multifaceted and unique to each individual. For some, their identity may be most strongly tied to their ethnicity, for example, an Italian-American may perceive themselves to be members of an ethnic group, in a largely symbolic manner (Ortiz and Telles 2012). Others may tie their identity to their race, which implies a ranking along a racial hierarchy and which carries palpable social consequences. Based on this group membership, individuals may encounter stereotypes which define how they should behave or who they should be; or they may encounter discrimination where they are treated differently due their group membership (Ortiz and Telles 2012). Not only does the individual from the "minority group" identify in a particular way but so does the person in the "dominant" group. However, those who claim membership in the dominant group are not constantly reminded of how their identity fits into society. The privilege an individual has in a society, present for members of a dominant group, can perpetuate social inequalities, especially if the individual or group is not aware of their privilege (Holm et al. 2017). Not having awareness of one's own privilege, or approaching race and discrimination with a post-racial ideology, leads to covert forms of discrimination.

Microaggressions are words or actions that may seem more subtle or surreptitious but are still insulting and discriminatory (Fleras 2016). Words in particular can seem innocuous, and the meaning can perhaps be open to interpretation depending on who is speaking and who is receiving the words.

> The social context of language, the power of language is not in the words that hurt, but about those patterns of power perpetuated through word play and language use in everyday discourses and daily practices. This assertion alone makes it doubly important to expose how the language of words exemplified by racial micro-aggressions constitute a discourse in defense of dominant ideology. (Fleras 2016, p. 6)

Microaggressions are less blatant to the untrained observer than an obvious insult or harmful action, but they are still harmful and hurtful. Augie Fleras (2016) compiles several examples of racial microaggressions in the following table

Examples of racialized microaggressions

Expression by transgressor	Interpretation by the microaggressed
Where are you *really* from?	You are a perpetual alien because of appearances
Those people...	"Outing" the other as remote or removed
You speak good English	Who would have thought you could be so articulate, especially since eloquence is beyond the intellectual reach of your kind

Expression by transgressor	Interpretation by the microaggressed
You are a credit to your race	Your group is usually not this smart
When I look at you, I don't see race	Denying identity and people's lived experiences
There is only one race, the human race	Denying the person as a racial/ cultural being
Clutching a purse more tightly	Criminal alert!
Following a customer of color in a store	Acting on stereotypes ("criminalized while shopping")
Being ignored at a counter	You are less valued/Whites get preferential treatment
Taxi passes a racialized person for a white fare	You are dangerous; you are a second-class citizen
I'm not racist, I have Black friends	Friendships do not exclude microaggressions
As a woman, I know what you are experiencing	I can't be a racist because I'm like you
Everyone can succeed if they work hard enough	Minorities are lazy or incompetent
It's a post-racial society	Race is irrelevant to success; accept blame
Asking minority person to settle down; be quiet	Pathologizing communication styles
Mistaking a racialized minority for service worker	Minorities occupy menial jobs
	(Fleras 2016, p. 7–8)

These are only a few examples of microaggressions; other examples exist that include issues of culture, such as cultural beliefs, religion, and religious practices. Depending on the interactions had by the individuals or groups, these microaggressions can become more escalated and be seen as a more overt act of aggression or discrimination.

The following vignettes illustrate some instances of microaggressions rooted in cultures and traditions.

Leila is a young Muslim woman who wears a headscarf and is active in her Mosque. Leila is usually the only Muslim student in her classes. She finds that her fellow students, and even teachers, turn to her when asking about what all Muslims believe and do. "Is that what Muslims believe?" "Why do Muslims hate women?" "Do all Muslims hate Americans?" Although Leila can generally recognize that these questions come from ignorance and lack of information, she still finds them offensive and hurtful.

Paolo lived in Brazil until his teens, when he moved to the United States to study engineering. Paolo grew up speaking Brazilian Portuguese, although he learned some Spanish in school. Paolo was surprised that his fellow students and friends would often ask him how to say words in Spanish, even though that was not his first language. "You're from South America! Say something in Spanish!" Paolo would hear. Paolo was often invited to Mexican restaurants, being told that perhaps he would want to eat some "comfort food," a comment that was not at all comforting.

Sam is a first-year medical student in the United States. Sam grew up in Nigeria and always knew he wanted to be a physician. Sam was surprised to find that in the United States, his fellow students and even professors would turn to him when asked about the minority or the "Black experience" in the United States. Sam replied that he did not grow up in the United States, so he did not have first-hand experience, but others always assumed that he could speak for an entire group of people.

Carmen grew up in the United States and was a third-generation immigrant to the United States. Her family still had strong connections to Mexico, and Carmen still had family members in Mexico. Carmen grew up with a very strong Catholic faith, and this was a very important part of her life. Carmen had been diagnosed with depression in her 20s but didn't want to share this with anyone in her community, for fear that they would judge her faith. Carmen worried that she would be told she was not praying enough, or that she was losing beliefs, because she was taking medication for depression.

Mi na grew-up in Korea and came to the United States to complete her PhD. Mi na and her husband are expecting their first child and have no family in the United States to support

them and have made few friends, so they rely on each other. In one of her OB/GYN appointments, Mi na shared with her nurse that she had experienced several dreams telling her that the baby would be a girl. The nurse became a little worried that Mi na was having visions or hallucinations, but Mi na assured her this was Korean tradition. When asked about her "birth plan," Mi na stated that she just wanted the baby to be born and that she didn't want to tell the doctors what to do. The nurse again questioned Mi na, saying that perhaps Mi na was not invested in this pregnancy and worried that Mi na may be depressed or detached from the pregnancy. Mi na did not see the need for a birth plan, because this was not something she had ever heard of, and this was not commonplace in Korea, and she did not want to disrespect the doctor and the medical team by assuming she knew more than they.

Misunderstandings can occur out of insensitivity and lack of knowledge. Many times, humans react out of fear when they are encountered with something unfamiliar—however, rather than reacting out of fear, if we are able to learn from these encounters and grow, we can become kinder and more empathic humans.

Conclusion

Keeping in mind our own privilege, as well as an awareness of how we see ourselves in the world, can help us understand how others see themselves in the world. In a professional setting, it is particularly crucial to recognize the prejudices, biases, and information that we have in our mind, to be able to see them as objectively as possible when encountered with any human interaction. Treating another human with the dignity and respect that any human deserves is ultimately what we strive for in any interaction.

Recognizing that there are differences and similarities in humans, and recognizing the stories and journeys each individual carries within themselves, both personal and historical, is what allows us to work collaboratively with the human in front of us and see their whole integrated self, rather than only pieces of the whole.

Fig. 4.1 Encounter of cultures. (Original artwork by Ana-Marcela Maldonado-Morales)

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Part II

Working with Families of Various Ethnic and Social Backgrounds: Common Issues, Challenges, and Misconceptions

5 Working with Hispanic Families During the Perinatal Period and Early Childhood

Sarah Johnson-Cardona, Sarah Caldera-Wimmer, Trevalova Augustin, and Maria X. Maldonado-Morales

Introduction

This chapter will explore the diversity among Spanish-speaking Latinos in the United States, as well as highlight shared experiences of individuals immigrating to the United States from Latin America. Latinos immigrate to many countries, and there are significant populations in Spain, the United Kingdom, Sweden, Canada, and many other countries. However, the great majority of this migration is to the United States, and we focus on the challenges of this population which may be quite similar to those faced by Latinos in countries not in Latin America.

Specifically, challenges immigrants face upon coming to the United States will be discussed with the objective of assisting clinicians in engaging and serving this population. To this end, the chapter will be divided into four main sections: (1) factors that contribute to a Latino identity starting from infancy, (2) common themes to consider when serving this population during the perinatal period and early childhood, (3) the impact immigration has on children, and (4) suggestions for clinicians of various professions and agencies working to make their services more accessible and welcoming to this community.

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Factors Contributing to Sense of Identity

Ethnicity and "Race"

"I'll check the box if it says Latino, but I won't check for Hispanic. I don't like that word," a Latina client explains. For some people, the term Hispanic reminds them of Spain, the *conquistadores*, and represents the destruction of their culture and land, a part of their identity and history they would prefer not to remember, much less include in a description of their identity. Latinos are not a homogenous culture; there are twenty-two Spanish-speaking countries in the American continent, each influenced to varying degrees by their own indigenous culture, colonization, and slavery. To assume that someone from El Salvador will have a similar perspective and culture as a Colombian would be to fall prey to the false narrative that often paints a shallow image of Latinos.

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Latino, Hispanic, and Latinx are terms to describe an ethnicity; since Latinos vary immensely in appearance and skin color, ethnicity is the only way they can be categorized. Telles and Ortiz (2008) explain that members of a dominant societal group develop ethnicities when they see themselves as different from the "other group" and want to firmly outline their dominance and protect their perceived superiority (p. 211). Given that Latinos cannot be defined by any one "race," census checkboxes oftentimes leave darker-skinned Latinos without an option; "I'm not white, but I'm not black. What do I mark?" is a common response when confronting the question "What race are you?"

Mexicans were the first to bear the burden of responding to the United States census. After the United States taking over of much of Mexico in 1848, *white* became the de facto predominant group (Gomez 2007). A few decades later, Mexicans were officially granted US citizenship with "full rights" but lost much of their property and were given low-status positions (Ortiz and Telles 2012). Although Mexican Americans are considered *white* on census documents, they are often treated as second-class citizens.

The United States is not the only country plagued by inequalities tied to the color of their skin; indeed skin color is a preoccupation in many if not most cultures. Telles (2004) described how Latinos of African descent, living in Brazil, experienced more discrimination, had lower socioeconomic status, and fewer occupational opportunities than those not considered of African descent. How skin color and other physical properties affect Latinos living in countries with less pigment variation has been more complicated to define. Villarreal (2010) interviewed 2400 adults in contemporary Mexico asking them to identify their own skin color (i.e., white, light brown, dark brown), socioeconomic status, level of education, occupation, and household income. In analyzing the data, Villarreal found that darker skin was positively correlated with lower educational attainment and socioeconomic status.

These findings support Massey's (2009) assertion that humans are wired to create schemas to represent members within groups. In the United States, Latinos with lighter complexions might be told that they do not "look Latino," questioning their sense of identity and belonging. However, in some cities in the United States, they may also feel marginally protected from police officer's threats to ask for legal documentation from anyone who looks Latino or, more commonly stated, "who look Mexican." Latino parents may feel the need to protect their children in different ways, depending on how "dark" each child is: the impact of color appears inescapable.

Language and County

In South America, Central America, and Spain, Spanish is the main and, in some areas, only language spoken. Of course, speaking Spanish does not define one's identity. Learning to speak Spanish does not make one Latino; however, not speaking the language can profoundly affect one's understanding of the Latino identity.

Although Spanish is the primary language, it is not the only one.

Isabel described how she arrived in the United States from Mexico and why she decided to come. She spoke slowly and with noticeable effort. The clinician asked if she spoke any languages besides Spanish. Isabel responded that she spoke Nahuatl, the Aztec language. Spanish was her second one, and she'd learned it in the United States because no one in her community could speak Nahuatl. She shared her experience of discrimination not only from nonimmigrants but also from those in the Latino community who made fun of the way she spoke, refused to repeat things, and overall treated her poorly. This is consistent with Villarreal's (2010) explanation that much of the discrimination in Mexico is between indigenous and nonindigenous populations. Isabel was in the United States because her family in Mexico did not have food or adequate clothing. At this point in the conversation, she took a deep breath and told the social worker that her father was sick and could not pay his medical bills. She explained that the medical system where she was from was not like it is here, "Si no puedes pagar, aunque estés por morir, no te van a

ayudar." (If you cannot pay, even if you are about to die, they will not help you.) She was sending money so her father could get the treatment he needed. Isabel wiped her eyes and described how she tries to think about her father's treatment when other Latinos excluded her because of her language.

As Isabel's story demonstrates, an immigrant brings with her schemas learned through socialization in her home country and now must learn the subtleties of social interaction within and between groups in the new country. This involves not only learning about obvious structures and dynamics such as immigrant versus nonimmigrant but also considering those less obvious schemas that categorize Latinos as separate from one another, such as country of origin, educational level, and language. Many are more likely to feel their identity tied to a region or country than any other characteristic of "being Latino." Stereotypes form about entire countries and individuals separate themselves based on these stereotypes.

Even if no stereotypes are at play, the experience of growing up in each Spanish-speaking country is different. Someone from Guatemala may feel excluded at an event with mostly Argentines. Their accent is different, they may not understand all of the vocabulary or slang, and the issues of these countries differ vastly. Someone growing up in the United States would not have their cultural identity lumped with someone from Australia, England, Ireland, Tanzania, or Singapore even though English is the official language in these countries. Although US citizens growing up in different regions will have diverse accents, references, and customs, they can vote in the same elections. Language is a unifying variable for people growing up in South and Central America; and as we have explored, this is not enough to create a unified identity.

Immigration Status and Identity

An individual's identity is related to what it looks and feels like to be Latino, which greatly depends on one's immigration status. The following cases explore the different experiences of two immigrant women.

Sofia came to the United States on a Fulbright scholarship to obtain her masters in linguistics. She fervently studied English since age twelve; she has an accent; there are words she does not understand; sometimes she feels shy but is able to communicate effectively and eloquently. She attended a well-known university in Colombia for her undergraduate degree and was at the top of her class. She came to the United States while the drug-related violence was at its peak, and the nightly news reported on the day's kidnappings. She, along with most Colombians, lived with some level of constant fear. The opportunities she saw for herself in Colombia were bleak; she searched for other options and applied to a Fulbright scholarship which allowed her to obtain a master's degree at a university in the United States. As she got off the plane and set foot in Miami, Sofia knew that her student visa would allow her to stay for 2 years. There were people at the university who could help her consider different immigration options to prolong her stay.

As it turns out, while Sofia was studying, she met a fellow student, who was a US citizen. After getting married she had a pathway to citizenship. They started a life in the Midwest and have three children. As the years passed, she reached a point when she had lived in the United States longer than in Colombia. The hardest pieces of her journey are balancing the possibility of a better life for herself and the guilt she feels for being so far away from her family. Immigration may bring great joy and opportunity but comes at a great cost.

In contrast

Mariana came to the United States by crossing the Mexican border. She decided she would make the journey at 21 years of age. She could hardly remember her life before being sexually abused by her father. She thinks the abuse must have started when she was a baby and believes this is why everyone describes her as a "sick baby." She watched as her father sexually abused her sister, ultimately resulting in her

sister birthing three of his children. She grew up in a small town in Mexico and was not allowed to go to school. She takes a deep breath before describing what she did every day, "Yo limpiaba el popo de las vacas," or "I cleaned the cow's poop." She also describes her feet constantly burning: "La tierra era muy caliente, y yo no tenía zapatos," "The ground was very hot, and I didn't have any shoes." There was a school in town, but the supplies were expensive, and her family did not have money to buy them. She was shunned by her peers and their families. They talked behind her back and consistently called her names. When she was 19, she was able to convince her father to allow her travel to a bigger town in Mexico to find work. She told him it would be good for everyone, because she would send money. She is grateful that somehow her father accepted. This was the last time she saw him.

In the big city, she had trouble finding a job and sent very little home. She was hungry. Her father started to pressure her to return. She knew upon her return, the abuse would resume. She had an immense fear of her father impregnating her, which would keep her stuck forever.

Just like Sofia, Mariana looked for the available options, and the only option she saw was crossing the Mexican border into the United States. She knew that life there would not be easy. She had heard countless stories of women being sexually abused on their journey to the United States, of people getting sick and even dying on their way. Yet, anything seemed better than the torture of her own home. She crossed the border with no knowledge of English, limited reading and writing skills in Spanish, and no set plans.

She now has a son and a daughter, and one of her greatest fears is ever having to go back to Mexico. She doesn't want her children to know their grandfather and fears for her daughter's safety if she is ever to meet him. Mariana works from 6 a.m. to 4 p.m., making egg rolls in a factory. She lives paycheck to paycheck, and her electricity often gets disconnected, creating repeated crises. When she has money, she sends it to her mother to buy food. She is constantly tired, has a variety of health problems, and yet is eternally grateful to the country that gave her a second chance at life.

Common Themes When Working with Latino Immigrants

Religion and Spirituality

The majority of Latinos in the United States identify themselves as Christian; in their review, Stolley (1997) describes that approximately 90% of Latinos declare themselves as Catholic, and 75% report attending a religious activity weekly (p. 35). Additionally, Latinos have been shown to become more active in religious activities as they age (Stolley 1997). Together, ethnicity and the church serve a role in conserving ethnic customs, language, and solidarity (Calvillo and Bailey 2015). In addition to ascribing to religions such as Catholicism and Protestantism, Santeria and Espiritismo may also be included in the belief systems of some Latino subgroups (Kramer and Lu 2009).

The opinion of the church or the church's view on mental health and treatment can greatly influence how one seeks treatment. Latino immigrants are more likely to seek counseling or treatment from general health providers or from the church or clergy than from mental health providers, and less than 1 in 20 Latino immigrants receive services from mental health professionals (NAMI 2006).

Mariana told a close friend about crying spells she was experiencing. Her friend encouraged her to pray to God for happiness and relief. When the crying did not cease, Mariana sought counsel from her priest.

It is important to understand the role of religion in mental health for Latinos and incorporate spirituality, clergy, and religious practices in treatment as appropriate. Of course, not all Latinos identify with Christianity in the same *way, and their relationship* with the church or God should not be assumed but explored as one aspect of the evaluation process. Additionally, forming relationships with pastors, priests, and clergy may be helpful in providing quality

services for this community, as well as reaching them.

Somatization

Keyes and Ryff (2003) describe somatization as "the expression of physical symptoms in the absence of a medically explained illness" (p. 1833). As is clear from both Mariana and Sofia's story, many immigrants come to this country in some way impacted by their experiences of past trauma. Somatic symptoms are common reactions to traumatic experiences across populations. In his book, *The Body Keeps the Score,* Van der Kolk (2014) describes, "The lives of many trauma survivors come to revolve around bracing against and neutralizing unwanted sensory experiences" (p. 205). Thus, when working with any individual who has experienced trauma, being aware of body sensations and their somatic experience is essential.

There is some evidence to suggest that Latinos may be even more likely to report somatic complaints. Escobar et al. (1987) found that in their sample of 3132 community respondents in Los Angeles, Mexican-American women over the age of 40 reported more somatic symptoms than their non-Hispanic white counterparts. Interestingly, this difference was only present among women. These authors also found lower levels of acculturation to be associated with higher levels of somatization. Their findings provide further support that therapists and physicians need to be aware of the presentation of these symptoms in their clients/patients.

Choice of language (English vs. Spanish) might also play a role in determining the intensity with which symptoms are described. With a sample size of 152 youth (ages five to seventeen) and their parents (majority mothers), Pina and Silverman (2004) compared how Cuban American Latinos, non-Cuban American Latinos, and European American youth meeting *DSM-IV* (*Diagnostic and Statistical Manual, version IV*) criteria for an anxiety disorder described their symptoms. Authors found that the results depended on the language in which the youth choose to take the assessment. When the assessment was taken in English, Cuban Americans reported perceiving their somatic symptoms as less distressing than non-Cuban Americans. However, when youth choose to take the assessments in Spanish, non-Cuban Americans reported their symptoms as more distressing than Cuban Americans. Regardless of language choice, Cuban American and European American parents described fewer somatic symptoms in their children than did non-Cuban Latinos. Language choice, and how this affects client's reports, may be particularly important for clinicians to consider when working with interpreters, as perhaps the nuisance or severity of the perceived intensity of symptoms may be lost in translation.

Whether the presence of somatic symptoms influences an individual's perception of their need for mental health treatment or prevents people from accessing mental health services were research questions explored by Escobar et al. (2010) and later by Bauer et al. (2012). Escobar et al. (2010) used a sample of 4864 participants who were identified as Latino, Asian, and non-Hispanic white and found that three or more general physical symptoms were associated with both the presence of a psychiatric disorder and service utilization, regardless of ethnicity. However, those identified as white non-Hispanic utilized mental health services at significantly higher rates than Latinos or Asians. Bauer et al. (2012) analyzed data from a National Latino and Asian American (sample size of 2554 Latinos and 2095 Asian Americans) to see if somatic symptoms impacted individual's perception of need for mental health services. These authors found that for first-generation Latinos, somatic symptoms were associated with both their perception of need of mental health services and their use of these services; this was not the case for third-generation Latinos.

Perhaps the biggest takeaway for clinicians from this research is how necessary it is to pay attention to clients' perceptions and reports of somatic symptoms, take them seriously, and explore their potential connection to emotional disturbances. Therapists and doctors providing psychoeducation on the physical symptoms

commonly presenting with different types of mental health disorders may also be helpful in serving to inform clients, reduce stigma, and even in relieving some anxiety.

Brujeria

One explanation for increased somatic symptoms in some cultures is the understanding of body and mind as connected (Bauer et al. 2012; Maldonado-Duran and Aisenstein 2011); this may also be an explanation for the presence of culture-bound syndromes. The influence of *Santeria* and other spiritual practices on Catholicism and mainstream Latino culture has created several culture-bound syndromes or illnesses that are a combination of psychiatric and somatic symptoms considered to be a recognizable disease only within a specific society or culture (Maldonado-Duran and Aisenstein 2011). From clients and patients, authors have learned that mental health symptoms may be attributed to having *mal de ojo/evil eye* (thought to be caused by someone who is jealous sending evil thoughts and energy toward the other person), due to some other form of hexing, witchcraft (*brujeria*), or ill will. In these cases, individuals are more likely to rely on home remedies, or *remedios*, to treat symptoms. For example, performing *una limpia* (*cleansing*), or rubbing an egg all over one's body is believed by some to clean one's energy or body. In addition, first seeking help from a trusted person such as a *curandero*, or healer, is common (Maldonado-Duran and Aisenstein 2011). It is always important for providers to ask the individual or family what they believe to be the cause of the symptoms (Torres 2015). Feelings of judgment or skepticism could cause a client to decide not to engage or terminate services. A better understanding of cultural beliefs as well as genuine curiosity to learn more can assist the provider in building rapport and creating a multidimensional approach to treatment which considers the client's belief system.

Providers can also inquire about what types of healing practices have already been pursued. These could include *limpias*, fasting, prayer, massages by *sobadores* (from *sobar*- soothing through touch), wearing certain jewelry (like something with red color or coral beads), completing rituals with certain oils, and herbal preparations and supplements (Kramer and Lu 2009). Being aware of these practices is particularly important with prescribing or discussing the possibility of taking psychotropic medication. Among the more rural Latinos, these are often seen with great suspicion and fear of becoming addicted.

Intimate Partner Violence

Intimate partner violence occurs across cultures, race, ethnicity, and socioeconomic status (Kantor et al. 1994). Although some studies have shown that rates of intimate partner violence within the Latino community are not statistically different than rates within the white non-Hispanic community (Caetano et al. 2004; Kantor et al. 1994), factors such a documentation status, substance abuse, and pregnancy may serve as predictors of intimate partner violence within a Latino community (Van Hightower et al. 2000). Clinicians understanding the context in which intimate partner violence begins for many undocumented clients is important in order to effectively and compassionately work with clients in these situations. Below are two case studies which illustrate important factors to consider when working with undocumented immigrants in violent intimate relationships.

Belen grew up in a small town in Mexico. Her mother suffered from untreated mental illness and as a result physically and verbally abused her daily. Belen never met her father; her mother had many partners, all for a short time. She states that from a young age, she was convinced of her worthlessness, "la vida de los demás hubiera sido mejor si yo no hubiera nacido," or "others' lives would have been better if I had not been born." At age 10, her mother walked into the room where she was being sexually abused by her uncle and subsequently beat her for "letting this happen." Things only got worse, and by age 16, she was tired and wanted a way out. She met

someone, a 30-year-old man, who offered an exit. He would take her out of Mexico and into the United States. No one in Belen's family objected.

She crossed the border with him and left one prison to enter another. She was not in love with this man, although also describes being unsure of what being in love means. The first night in the United States, he positioned her to have sex, and she did believe it was an option, to stop him. "Eso es lo que tenía que hacer," she says. "This is what I had to do."

Belen was searching for an escape from her pain and from the people who hurt her. In this search for escape, she became more vulnerable to falling into the hands of another abuser. The setup is conducive both for beginning the honeymoon period of an abusive relationship and engaging the partner in a power dynamic. This potential partner provides the way out, the salvation, and a glimpse at the possibility of feeling loved and valued. If one's deepest desire is to escape, and there are no apparent alternatives, how can this opportunity be turned down?

She experiences both physical and sexual abuse from her partner and still describes it as better than what she used to live. She wishes the childhood pages of her life story would have been written differently; she wishes more options for escape would have been possible. Yet, if given the same alternatives, she would still fill the pages of her story with abuse from her husband in the United States rather than more of the abuse she lived in her home country. Belen and her abuser now have four children together.

When it comes to intimate partner violence, the question of why the victim does not leave is always posed. Belen views her options without her husband as dark. She grew up without a father and does not want the same for her children. Although staying with her husband will undoubtedly affect how her children view relationships, she is more afraid of their physical and emotional survival if she leaves their father. She also lacks the belief that other men could be different. To understand her belief system, her therapist asked her how she would respond to her daughter if she told her she was being forced to have sex. Belen said she would tell her, "Que todos los hombres son asi." "All men are like this."

She watched her mother suffer constant abuse by men that left her, and Belen's own history is filled with men who have hurt her. The few friends she has share similar experiences and describe that enduring physical and sexual abuse is their "duty as a wife." The ending of Belen's story is yet to be determined, but she is better off than many because she has been able to seek help.

Another client, Josefina, was with her abusive partner for eighteen years, before she ultimately decided to leave for good. In those eighteen years, she left for periods of time, but her electricity would be disconnected, her children would complain that they missed their father, and he would promise her he had changed and that he loved her more than life itself, and so she would return. In the final incident that led to her abuser going to jail, Josefina was able to summon the courage to ask her social worker to accompany her to the police station to file the police report. The social worker was able to help with the language barrier, and Josefina felt that with her social worker present, the police officer would not focus on her documentation status. While her abuser was in jail, he constantly sent her letters both describing how much he loved her and how everything was her fault. After he served his sentence, he once again began stalking her and threatening her current partner. "Nunca me va a dejar en paz. Si lo deportan, él va a empezar a molestar a mi mama en México. Ya me lo ha dicho. Yo no se que le hará a mi mama." "He will never leave me in peace. If he gets deported, he will start to bother my mom in Mexico. He has already told me he will do this," Josefina explains.

Providers must express compassion and validation for the reasons clients may now find themselves in an intimate partner relationship, as well as safety plan with clients, respect the client's right to self-determination, and be careful not to paint an unrealistic picture of what it will be like to leave the relationship. Clients are often in the most danger of death when they choose to leave (Tjaden et al. 2000), and only the woman herself can fully understand the lengths to which their

abuser is willing to go to torment (or end) their life. Providers need to be aware that safety planning is a constant process that does not end nor begin when clients leave the relationship. Additionally, conversations with a social service worker may be the first time the client has felt free to entertain the possibility of leaving, as close family members may be telling them the opposite, or excusing the abuser's violent behavior with comments such as, "O simplemente es un hombre celoso, todos los hombres son asi," "Oh he's just a jealous man; all men are like that." Leaving an abuser is not the same in all contexts, and in an environment where comments like these are all the client hears, it will take more courage and planning to ultimately find a way out, if that is the choice made. Additionally, clinicians in the United States and other countries with mandated reporting laws, as some states, require a hotline is made to children's division for all families where physical violence is occurring between parents, and other states do not. Including children in safety plans and finding accessible therapeutic services for children are necessary steps in promoting the families' well-being.

The Impact of Immigration on Children

Forming an Identity

Sofia and Mariana both made the choice to find their way into the United States; both of their choices were centered around the search for more opportunities, escape from danger, and the possibility of a better life. With time, the United States will become part of their identity, part of their every day, and part of how they raise their children. Depending on their interactions in the United States, the color of their skin, English proficiency, accent, education, literacy level, income, and documentation status, they will spend moments, periods, or a lifetime feeling that they do not belong in the United States and yet retain a deep desire to stay.

Children born in the United States to Latino parents also struggle with their identity; they may feel as they fit into what it means to be Latino in the United States but not what Latino means in their parent's home country. They may be defined as Latino in the United States and as "gringo" or American elsewhere. Even if their parents only speak Spanish in their home, their accent often does not match the accent in their parent's country of origin. Thus, when in their parent's home country, they will be asked where they are from. This can be difficult if they feel their parent's country of origin holds part of their identity. Some children have the experience of being told they speak English well when they are in the United States and that they speak Spanish well when they are in the Spanish-speaking country—as if neither was their language and thus both surprising.

Many undocumented immigrant youths feel stuck between two worlds: two countries, two cultures, two languages. They cannot go back to their home country because they have no resources there but also feel unwanted in the United States, labeled as "illegal" and consequently as criminals. Adolescence is a time of trying to develop one's identity, and this can be even more difficult for minority adolescents for reasons of language, physical features, and social stereotypes (Spencer and Markstrom-Adams 1990).

In Sofia's case, her husband is from the United States and speaks Spanish. They speak only Spanish at home so that her children learn Spanish. However, she could have married a man who did not speak Spanish, and in that case, her children might be monolingual. Even with both parents speaking Spanish, teaching children is not easy, and for a multitude of valid reasons, children of Spanish-speaking parents may not learn the language fluently. If parents' English is limited, this can create communication difficulties within their families. In some families the children have "forgotten Spanish," and one or both parents only can understand and speak Spanish, creating a barrier between them.

Using "Spanglish" can serve as a way to generate a sense of belonging—two friends who both

have parents from Spanish-speaking countries and who grew up in the United States might speak to each other mainly in English but use Spanish words occasionally. They understand each other perfectly and can say whichever word occurs to them first. The ability to communicate in this way can increase their sense of connection. However, the use of Spanglish can also serve to isolate.

Elsa, age 21, a "Dreamer[1]" grew up in the United States, and speaks a fluid blend of English and Spanish. She understands both languages, but her spoken thoughts can sound to others like a garbled version of Spanish. After Elsa's baby's arrival, she began attending a Spanish language support group. While she understands everything, she has a hard time presenting her thoughts and comments in Spanish. After the group, she explains her appreciation for the information and community but feels "very different from the other ladies."

The struggles of identity and belonging are not bicultural children's defining features. They may feel split between two countries, but this can foster a deep understanding of both differences and similarities between humans and countries. As they continue to accept and develop their identity, learning to feel comfortable within different cultures can help them quickly adapt to new situations and have empathy for those with different experiences. They learn and represent that despite many messages to the contrary, first and foremost we are all human. Those who are bilingual are a big part of the solution to improving access to services for the Spanish-speaking Latino population in the United States. For many second-generation immigrant children, there is also a sense of internalized discipline and responsibility to take advantage of the opportunities available to them based on their parents' immense sacrifices.

Raising Children in the United States

Immigrant parents profoundly desire to instill this sense of discipline and responsibility in their children. Sofia explains, "One of my biggest fears as a mother was that my children would end up being ungrateful. It was my impression that in the United States children were given everything they wanted. That was not my case in Colombia, and I want my children to appreciate the work that goes into everything they have." Mariana describes how she has spent hours trying to convince her eleven-year-old daughter that she is too young to get her eyebrows waxed or to shave her legs. Her daughter pleads with her because all of her friends are doing these things and boys at school are calling her "a bear" when they see her unshaven legs. To Mariana, these conversations are incredibly foreign; she was concerned about having shoes, not the thickness of her eyebrows. Mariana works to maintain her flexibility, reminding herself that these conversations are proof of the new life she's created; yet, she feels her daughter is constantly pushing her limits. Martinez et al. (2011) echo Mariana's comments, as they describe that parent's attempt to teach their children values from their home countries can be a source of conflict. Children may feel parents do not understand anything about their needs or what it means to grow up in the United States.

Belen's story provides another example of what it is like to raise children in the United States. Soon after arriving, she became pregnant. A few months after her daughter was born, her husband was deported. She was alone, at seventeen, with a newborn, no documents, unable to speak English, and no idea what to do. She decided to go back to Mexico to be with her husband, her only "protection." There they stayed until their daughter was two-years-old. Faced with continued abuse from her family, limited food, and the desire for her daughter to have a life

[1]The Deferred Action for Childhood Arrivals (DACA) was a government program created in 2012 under President Barack Obama. The program served to allow undocumented children entering the United States at age 16 or younger to live and work legally without the possibility of deportation. The young people protected under DACA are called "Dreamers," because the program that became DACA was called the Development, Relief, and Education for Alien Minors (DREAM) Act (The Guardian 2017).

different from her own, Belen and her husband crossed the border again. Belen did not think it was safe for her daughter to cross with them and decided to leave her in the care of an aunt. A citizen uncle brought Belen's daughter to the United states two months later.

Belen described that her daughter wanted nothing to do with her when she arrived in the United States and kept yelling for her aunt. Suárez-Orozco et al. (2011) *describe Belen's daughter's experience as two different attachments disruptions, one from the parent and the second from the caregiver to which the child attached in the parent's absence (p. 224). Through tears, Belen describes this as was one of the hardest periods of her life and still feels tremendous guilt for leaving her daughter. She worries this may have caused irreparable damage in their relationship*. Belen is one example that others need to leave their children for much longer, potentially causing increased tension in their relationship and attachment trauma for the child. Fathers may leave their children for multiple seasons a year, to work in the United States and send money back home. It is not unusual for children who have been separated from their parents to feel anger toward their parents for leaving them as children and in some cases also taking them away from their current caretakers (Suárez-Orozco et al. 2011).

Marisol was separated from her parents, Adela and Francisco, for much longer than Belen was from her daughter. Marisol's parents left her with her grandmother when she was nine-years-old and were finally stable enough for her to come to the United States when she was fourteen. Marisol describes being resentful that her parents took her away from her familiar surroundings in Mexico, to a new city where she is not familiar with the culture, language, and has no support system. She struggles to make friends at her school, because she feels very self-conscious about her English-speaking abilities, and finds it easier to keep to herself to avoid potential embarrassment.

Suárez-Orozco et al. (2011) describe that parents' feelings of guilt over the separation can result in inconsistent discipline and overindulging the child, causing further complicated family dynamics (p. 225). Francisco and Adela report giving Marisol anything she asks for, but despite all their efforts, Marisol does not confide in them, behave, or treat them in the manner they feel she should. Francisco is concerned that her daughter is quickly getting out of their control. Adela often feels frustrated because she tries to model the behavior she wishes to see from Marisol, but this seems to have no effect. Parents may feel they took away from their children the opportunity to be "Latinos" in the country of their origin, with different representations of what a family is, friendship, closeness, and support from extended family members.

Acculturation can be a struggle for immigrant parents and their children, especially if the children acquire behaviors from the new culture that do not fit with the parental culture. Many times "maladaptive" psychological responses are misinterpreted by teachers and parents and the child is dismissed as willfully "mean" or "disrespectful" and punished accordingly, which reinforces the response (Stirling and Amaya-Jackson 2008, p. 670). Children can find themselves in situations where they are misunderstood or their actions misinterpreted due to their developmental experiences.

Impact of Deportation on Families

Belen's daughter was too young to remember when her father was deported, but she knows this happened. She also knows she was born in the United States and that if her parents were deported, her mother would find someone in the United States to be her legal guardian. She knows her mother wants her to have the opportunities the United States offers; yet, she fears watching her mother being forced to leave and not knowing when she could see her again. She wants her mother present at the moments they have both worked toward (e.g., *her high school graduation) and knows if her mother is deported, this will be impossible.*

Children born outside of the United States fear their parents' deportation because they have

spent most of their lives in the United States and do not want to leave the only home they know. Many children live with the intrusive devastating images of what it would be like to watch the deportation of their parents.

Unfortunately, classmates might trigger this fear. These comments can be well-intentioned, "I heard on the news last night that Mexicans are being deported. I am really going to miss you," or can be a form of bullying—kids chanting, "Go back to Mexico." Either way, these comments hurt deeply and may result in children wanting to stay home to avoid these comments and ensure nothing happens to their parents. This leaves mothers and fathers navigating these difficult conversations. Social workers, mental health professionals, teachers, and health-care providers can help by holding space for parents to discuss their own fears and emotions. In turn, with their own needs met, parents will be more able to provide emotional support to their children in these potentially excruciating conversations.

Improving This Community's Access to Services

Current Access

Children's opportunities and development will largely be affected by how well their parents can access services. Sofia does not need to work with interpreters nor does she need to be given documents in Spanish; she has health insurance provided by her place of employment. It is more comfortable for her to speak in Spanish, but every day she spends in the United States, English becomes more natural. She can go to a therapist and describe her emotions in English with relative ease. If there is ever a word or idiom she does not understand, she can ask her husband.

Sofia interacts with many people in the health-care system who do not believe she is a citizen. She is excluded from certain conversations, and by certain people, because of her accent and darker skin color. On some days she is unsure others will ever believe she belongs in the United States. Yet, she will always be able to advocate for herself and for her children. With her income and her husband's income, she fits comfortably into the middle class. She lives in a white neighborhood, where her children go to an excellent public school. She has mostly white friends. She is not around the Latino community often. She visits Colombia every other year and brings her children. Every time she visits, she feels less like she is at home where she grew up while still missing her family when she is in the United States. Her heart is spread across two subcontinents. These are her challenges. Her challenge will not include external barriers to accessing mental or physical health services.

Unlike Sofia, Mariana knows very little English. Growing up, Mariana worked hard to teach herself how to read and write in Spanish; she learned how to write her name and phonetically sound out other words. She makes many mistakes and feels embarrassed. Mariana experiences more intense stereotyping and discrimination than Sofia because of her educational status, which is consistent with Ortiz and Telles' (2012) research. With this literacy struggle in her native language, learning English becomes extremely challenging. She works at a factory all day, which is filled with other immigrants, many of whom speak Spanish. She has no English-speaking friends. She comes home from work and takes care of her children. Sometimes they answer her in English, and she understands some of what they say but can only respond in Spanish.

She does not have health insurance. She avoids going to the doctor unless she feels "sick enough," in which case she goes to a community health clinic, urgent care, or emergency room. She needs interpreters. If she is lucky, the interpreter arrives on time, but more often the interpreter is late or never arrives. The interpreter may be physically present in the room or over the phone. When she has to communicate over the phone, she reports often not being able to hear what the interpreter is saying. She has had interpreters who are professional, speak clearly, remind the doctor to look at her, and interpret everything as it is said. Unfortunately, she has also had interpreters who interject their own opinions, tell her she cannot ask certain things, or shame her after

she asks questions. In smaller Latino communities, it is not uncommon that the client has a previous relationship with the interpreter and therefore does not feel comfortable disclosing personal information. To avoid all of these situations, parents often bring a child to interpret. All of this places the child in a parenting role, and can create an imbalance in the structure of authority within the household, and places unnecessary pressure and stress on the child.

As if all of this does not make the appointment hard enough, Mariana is constantly wondering what her rights are as an undocumented woman. She wonders how each person will treat her and is in constant dread of the question that always seems to come: What is your social security number? How will the person ask? What will she say back? How will they respond to her? Negative encounters have kept her away from treatment in the past.

The negative experiences that cause Mariana to avoid medical treatment make it that much more difficult to seek mental health treatment. Mariana would meet criteria for posttraumatic stress disorder. Due to her father's (and mother's) treatment of her, she internalized the belief that she was worthless. She wakes up at night with nightmares, her heart beating ferociously, and her entire body sweating. She lives in constant fear of having to go back to Mexico. She is alert to every danger, and she is deeply afraid that someone will sexually abuse her children. Yet, until a few years ago, she never received mental health treatment.

How to Make It Better?

If the interest is truly to provide women like Mariana with better medical and mental health services, many things need to change, including access to health insurance and a path to legal status in the United States. Perhaps easier places to start would be increasing the number of Spanish-speaking providers (both for physical and mental health), more in-depth training for physicians and therapists on how to use interpreters, and more reliable access to highly trained interpreters. Beyond this, it will involve looking around clinics and hospitals and asking the following questions:

Are there any pictures or art on the wall of people who represent this population?

When are clients asked for their social security number, and is it necessary to do so?

Could alternative questions be asked before requesting a social security number that would provide the same information and create less anxiety?

What is the literacy level required to read the brochures or information provided?

Is information provided in the client's native language? If yes, is this information as easy to access as the English versions?

When the client calls, is anyone available to talk to them in Spanish? If not, is an interpreter available? How will the client know the interpreter is available? Are clients given instructions on how to access the interpreter in a language they understand? Many times, the recorded voice gives the information for a Spanish line in English.

Is adequate time provided for clients to fill out forms, especially if literacy level is low? Is there anyone available to help fill out forms?

If the client is trying to speak English, but has limited English proficiency, how patient is the staff?

What is the policy around using family members, children in particular, as interpreters?

Receiving interpretation for a twenty minute medical appointment is much easier to tolerate and do effectively than the interpretation required for a weekly hour mental health therapy appointment. When necessary, and done effectively, participating in psychotherapy through an interpreter is beneficial and certainly better than no treatment. However, the likelihood of going to a therapist who does not speak Spanish is extremely low for someone who has difficulty advocating for themselves in English, is unsure of who to trust, thinks mental health treatment is only for those who are "crazy," and has never disclosed past trauma.

Without already having the community's trust, seeing a flyer for mental health services is

unlikely to be effective. Some level of trust needs to be established to decide to begin therapy. Successfully engaging Spanish-speaking, uninsured, and potentially undocumented clients in mental health treatment involves going out into the community and gaining their trust. This could look like having an information table staffed with Spanish-speaking providers, resources, and basic need items stationed at a well-attended Spanish mass. Partnerships with churches can be key because the church is a sanctuary, comfortable, and trusted place for many Latino families. Potential clients who see that the providers really do speak Spanish, are friendly, do not ask for their documentation status, and describe therapy in a way that could apply to them are much more likely to engage with the organization. Not having eligibility criteria in terms of diagnosis is also beneficial for engaging clients. Therapists focusing on the symptoms, behaviors, or situations in the person's life that would need to change for them to feel better is the best practice for engagement (Dixon et al. 2016). Focusing on diagnosis instead of specifically what the client reports needing can scare clients into thinking they are being labeled as "crazy." Intentionality about how and when to bring up the topic of taking psychotropic medication is also crucial for continued engagement with this population. Many Latinos have negative beliefs about taking medication and show a preference for psychotherapy over medication (Guarnaccia et al. 2005). Psychoeducation around identifying symptoms of depression, anxiety, and PTSD, as well information on reasons why mental health symptoms develop, may help clients self-identify a need for further support.

Engaging the community requires making treatment accessible, in terms of price, childcare options, and location. In some cases, this means going into their home. Serving this population means answering machines have recordings in Spanish and that *every* time a monolingual Spanish speaking person calls, there is someone who can answer in Spanish. It means having signs and all resources in Spanish. Offering multiple services through one agency is also advantageous. For example, a few programs in St. Louis offer case management and basic need items, as well as mental health treatment. Many clients come in once because they need diapers, the next time because they need help filling out their food stamp application, and the third time they tell the case manager how they cannot sleep at night. This time the case manager has gained their trust and introduces them to the therapist; a connection is made.

Holding a series of groups covering a variety of topics, from how to enroll children in school to intimate partner violence, is another effective method of getting information into the community and allowing community members to meet services providers without ever having to identify the specific type of help needed. The impact of these groups and presentations cannot be underestimated. Belen obtained treatment because an acquaintance of her's heard a presentation, in Spanish, about intimate partner violence and mental health and gave Belen the presenter's number. Belen also knew and trusted the person who coordinates the group series, asked her about the presenter, and when she heard good things, she decided to call; she has now been engaging in therapy for almost 2 years.

When clients engage with a therapist through an interpreter, likely one of two things occurred: (1) the English-speaking therapist presented to this community, effectively used an interpreter in his/her presentation, and showed the community that he/she was willing to make the effort to reach them, or (2) someone who had already gained their trust helped them through the process of connecting with the English-speaking therapist and interpreter. If agencies who do not have Spanish-speaking staff want to increase their impact in this community, forming partnerships with organizations who already have Spanish-speaking staff working with the community would be a good place to begin.

Offering this population access to services is a huge step, but it is not enough. Services must be provided in a way that *keeps* client engaged. Lack of trust is a barrier to accessing potential services, and it is also a barrier to remaining engaged once beginning treatment. As described by Chang-Muy and Congress (2009), trust can be difficult

to establish with immigrants who are unsure of the rules of the new country and who may fear official sites. The authors discuss that it may be necessary for the therapist to disclose more personal information about himself or herself than they would with other clients to help establish that trust. This might also mean that more sessions are provided with this population than would otherwise be necessary, as the therapist holds the container for the client to go at his/her own pace. Beginning a structured treatment protocol such as trauma-focused cognitive behavioral therapy (TF-CBT), or the reprocessing phase of eye movement desensitization and reprocessing (EMDR) therapy, too quickly, before adequate trust and safety is established in the therapist–client relationship might lead to an even greater likelihood of the client leaving treatment than would be the case with other populations. Chang-Muy and Congress (2009) also discuss the notion of shame and guilt with immigrants, especially those who have experienced trauma or violence, and the frequent perception of their life events being in some way deserved or self-created. This may impact the time it takes to disclose all of their experiences, thoughts, or feelings, further highlighting the importance of establishing trust and longevity in the therapeutic relationship.

Other important factors to consider when engaging this population through the course of treatment are establishing clear boundaries around the relationship from the onset. For many clients, this will be the first time they have engaged in therapy or any type of formal service provision; thus, they will not know what to expect. It is up to the therapist to make this clear from the beginning to avoid any potential shame of "doing the wrong thing" later in treatment. For example, providing clear information and rationale around expectations for payment, policies for receiving gifts, interactions if seen in the community, rules around social media, mandated reporting, and what boundaries continue to exist after treatment has completed can avoid much potential future confusion and uncomfortable conversations. Mandated reporting of suspected child abuse and neglect may not be something that exists in the client's home country, and so this is something providers may need to spend extra time explaining. Additionally, parental behaviors that in the United States would be a reason to make a report to Children's Division may be the norm in the client's home country. Having conversations around these differences, explaining how different contexts impact how the method of discipline is perceived by the child, and helping clients to learn how these systems work in the United States are part of the providers job.

All humans deserve access to health services and this population is no different. However, they will not access services that are not developed with their needs in mind. If this country's health system is to become one that includes this population, practitioners, program directors, and organizations must make a consistent effort to include their voices and perspectives when making decisions. Once these efforts are made and trust is established and maintained, clients will become the agency's biggest supporters and allies.

Fig. 5.1 Role of the Father. (Original artwork by Ana-Marcela Maldonado-Morales)

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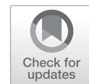

6 Working with African-American Families in the Perinatal Period and Early Childhood

Prakash Chandra and Dana Billups-Bradley

Working with African-American Families in the Perinatal Period and Early Childhood

Writing about cultural issues in "African-American" families is hard for several reasons. One is bound to make affirmations and reference data or studies that might be offensive to someone. This is in part because "Afro-American" is an inadequate term in the sense that it gives the semblance of uniformity to a very diverse set of communities. In a sense it is a "racial" term (if not racist) because the only criterion is the "color of the skin" and descendance from people who originally used to live in the African continent.

A more adequate description might make distinctions between "African-American" families from the South, from the North, or from urban and rural areas of the United States. Another would take into account socioeconomical status and other descriptions to consider customs, practices, etc. This approach might be more acceptable, as the more educated and affluent the family, different health and infant care practices are implemented, compared with other, larger in number, families who live in poverty and use different adaptive strategies to conditions of high stress. One might refer to African-American families living in economic deprivation and very different ones, who are middle socioeconomical class or higher income. We reject the monolithic view of the experiences of African-American women and understand that there are variations in presentations and behaviors in this group. We used the terms African-American family and African-American women in order to denote that this chapter is about experiences of the people living in the United States who identify as African-American or black, and we understand that they are diverse in size, shape, membership, and social class.

Unfortunately, the history of racial segregation and discrimination in the United States is very recent, and "officially" African-American people (who used to be called Negroes or "Blacks") achieved equal civil rights and were desegregated and able to vote only in the decade of the 1960s. Sadly this does not really mean that even when these laws are in the books, the country has become desegregated or that racism has disappeared. Like in many other countries, including many European ones, there is still widespread racism and discrimination. People from African ascendance tend to be in the lowest economical conditions in general. This does not mean there is uniformity among African-American families. There are ample sectors of

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highly educated families, who have "jointed the mainstream culture," and many have embraced the same customs and value and retain others from the previous generations. However, poverty itself remains high in the United states in terms of its prevalence, and the most affected groups are African-American.

As recently as the Nixon presidency, who declared a "war on drugs," it now appears that this was specifically a strategy designed to oppress African-American families and to "keep them in their place" with very high rates of incarceration for relatively minor drug offenses. This has been recently acknowledged by officials who were in the federal government at that time (Quadagno 1994). One of the goals was the breakup of families through massive incarceration, mostly of men (Hinton 2016).

Another reason for this "perilous writing" is that any affirmation or generalization might be construed to be a part of a tendency to describe African-American people of "negative qualities" or practices, which may reinforce or perpetuate precisely those stereotypes. Therefore, it is particularly important to highlight the resilience of African-American families facing chains of disadvantages and adversities decade after decade. We will focus mainly on describing traditional beliefs and practices, differences and similarities, and common stereotypes and misconceptions one might face while working with the African-American families.

African-Americans constitute the third largest ethnic and racial group in the United States. In 2017, the US census bureau estimated 14.6% of the total American population is Black, which includes "Black only" and as "Black in combination with another race."

The Transgenerational Effects of Slavery

This is a difficult question to answer, as there has been little empirical research on the effects of the experiences such as capture, forced transfer to another country, and enslavements of individuals or entire families. The institution of slavery lasted over 300 years as it involved the United States. However, it is tempting to attribute some of the stresses and problems of African-Americans entirely to an inheritance of slavery and overlooking the importance of current discrimination, inequalities, and economic stress (Cross 1998).

African individuals who were enslaved or sold in their country of origin usually were shaved and then deprived of their cultural practices as much as possible. Families might be separated because of the sales of different members as individuals. It would be surprising if these experiences, plus the hard lifelong labor, and being considered as a physical property to be sold in the market would not have transgenerational effects like other phenomena, such as the Holocaust. The effects have been shown also for Vietnam veterans, Native Americans, and descendants of refugees (Yehuda et al. 2018).

Many social scientists have interpreted distinct patterns in African-American family formation as both inherent (African-Americans are strong) and a reaction to past and current conditions (resisting systems such as patriarchy).

A study of descendants of actual enslaved persons, comparing them with "free" African-American individuals, estimated that in economic terms, it took two generations after achieving freedom for the descendants of slaves to have a similar socioeconomical status as the descendants of non-enslaved Blacks (Sacerdote 2005). This does not tackle the question of the psychological and emotional heritage, effects on child-rearing patterns, and parental beliefs, among many other questions.

There is much interest recently in the transgenerational effects of high psychosocial stress in groups, which through epigenetic effects on individuals transmit vulnerabilities for some conditions to the next generation. This has been studied in terms of gene modification and methylation of some loci of genes. The evidence suggests that stressors such as maternal deprivation and maltreatment, through epigenetic effects, may produce alterations in emotional regulation and hippocampal functioning, which could be transmitted to the following generations (Thayer and Kuzawa 2011).

Chronic and Multigenerational Social Stress

African-American families are more likely to experience social stressors in life than any other ethnic groups in the United States (Cutrona et al. 2006). A recent study found that 12% of African-American women who had experienced a negative life event in the previous year and lived in high-stress neighborhoods went on to suffer a major depressive episode compared with 2% of women who had experienced a negative life event and lived in low-stress environments. African-American women and families experience high rates of homicide, especially in disadvantaged areas, which results in many women grieving the loss of a loved one (McDevitt-Murphy et al. 2012). African-American children who are raised by female "householders" are five times as likely to live in poverty as those raised by married couples (Hattery et al. 2007). Employment is one of the strongest predictors of both access to financial resources but also to health-care services that are vital to healthy living, reduced infant mortality, longer life expectancy, and overall life chances. African-American families living in poverty means living in substandard housing. They are more likely to have trouble paying the rent on a regular basis and being behind on bill payment. These families are also more likely to go without one or more meals each day. There is more violence in those neighborhoods. Some cities, e.g., some areas of Chicago, have been considered as war zones, due to the high rates of homicides and crime in general. Many African-Americans and other poor citizens refer to their neighborhood as "the ghetto" (Rankin and Quane 2000). Although the concept initially was applied to minorities in Europe, it constitutes a reality for many poor African-Americans. The children will be exposed to all those stressors, will attend poorly funded schools, and it will be much harder for them to escape the poverty and the cycles of disadvantage and criminalization (Jones 2000). These impoverished areas can be observed in many cities in the world, like Paris, London, Sao Paolo, and many others.

In many "inner cities" in the United States, parents have to teach their young children to get on the floor when they hear "the shootings" outside. They are often kept inside the house, with little opportunity to take a stroll in the park or play outside due to the sheer danger of gun violence.

More than one million African-American men are in prison or criminal justice system. It is estimated that more than 250,000 children have a mother in jail and more than 1.5 million African-American children have a father in prison (Kjellstrand et al. 2012). This high rate of incarceration among african americans causes a significant stress and has a detrimental impact on the family structure, relationships, marriages, and future of the children. It will impact their educational attainment and their involvement with difficult and perilous situations and puts them at high risk of maltreatment.

Intimate Partner Violence

Intimate partner violence is one of the biggest threats to the health and well-being of African-American women (Roberts et al. 2010). About 90% of the violence involves men hitting, beating, kicking, choking, and sometimes murdering women. Aside from the effects on the woman, it has a serious effect on the emotional life of children and long-term repercussions. It has been shown that traumatic experiences associated with domestic violence transmit through generations.

Family Structure

African-American women and men are significantly less likely to marry (estimated 58%). Studies have reported that children (and adults) living in single-parent households are significantly more likely to live in poverty than are those living in two-parent households (married or cohabiting). Family structure can have a significant and detrimental impact on the African-American women and families not just during the perinatal periods but to future children.

Robert Hill (2003) proposed five strengths that have been culturally transmitted through ancestry to contemporary African-American families. The strengths that foster resilient families and members were identified as a strong kinship bond, a strong work orientation, an intense achievement orientation, flexible family roles, as well as a vigorous religious orientation (Hill 2003). The various "Black churches" are a crucial source of social support for families, in material and emotional terms, as well as to seek counseling and guidance.

As in many other cultures, family refers to the extended, rather than only the nuclear, family. Also, people may incorporate informally "brothers" and "sisters" who are friends, or people with whom one has close bonds, even if not biologically related. This has been suggested to reflect the instillation of a strong "sibling bond" as a part of the survival strategies of Black families in the past. In the clinical setting, at times a woman or a man could be introduced as a "sister" or "brother," and only later the clinician learns they are not related, and families can say "he is my play brother," meaning they pretend to be brothers or act as though they were.

There is a stereotype which describes Afro-American families as mostly headed by women and a relative absence of contact with fathers while the child is growing up. In the majority of families, there are two parents; however, there is a high representation of women who head the household compared with other ethnic groups. Around 45% of households are headed by a single woman, compared with 14% for Caucasian and 23% for Latinos (Johnson et al. 2003).

Grandparents tend to have great importance as they assist in caring for young children. Mothers often rely on their own mothers or grandmothers and grandfathers to assist them in providing child care when they have to work during the day, living arrangements, and financial support. In many families a grandmother may be the primary caregiver if her daughter or son is unable to care for a young child or children and becomes the custodian of the child (Snyder et al. 2006).

The Perinatal Period

Pregnancy is a period of "psychological vulnerability." African-American babies are twice as likely to die in their first year of life as are White babies. The average life expectancy for African-American women is 12 years less than that of White women. They also have increased rates of psychosocial stressors and economic hardships (Segre et al. 2006). This is a vulnerable group for developing increased rates of postnatal depression (Segre et al. 2006). Paradoxically the rates of diagnosis and treatment of prenatal depression are low among African-American women (Lara-Cinisomo et al. 2009; Geier et al. 2015).

There are also racial disparities in birth outcomes and infant mortality among American-African women, and there is increasing evidence that antenatal depression impacts these outcomes. We know that the stigma against mental illness negatively affects treatment-seeking behaviors among African-American women (Nadeem et al. 2007). Also, the general prejudices against this ethnic group tend to minimize the detection and diagnosis of emotional and behavioral disturbances, in their children. In men, even adolescents are more likely to be labeled as juvenile offenders or join the justice system than mental health systems. Such bias is also the result of the difficulty to access and pay for health services. Even if they do, the bias persists in not detecting some emotional problems in African-American children and diagnosing them as dissocial or with conduct disorders (Mizock and Harkins 2011). This pattern is also observed in schools, in which African-American children tend to have more disciplinary referrals and are dealt more punitively than Caucasian children (Ferguson 2000), i.e., the penalties are more severe (Monroe 2005).

African-American women have the highest rates of antenatal and postpartum depression (Luke et al. 2009). The estimated rates of prevalence of postnatal depression among African-American women range from 70% to 28%

(Beeghly et al. 2003). The increased rate is associated with economic hardships, poverty, and other psychosocial stressors (Segre et al. 2006). African-American women have higher single marital and low-income status which is reported as being predominant risk factors for depression. Many African-American women and families are part of the disadvantaged and vulnerable populations of the society, and they are more likely to suffer stressful life events. It makes them more vulnerable for developing depression as they feel less control over their surroundings (Hobfoll et al. 1995; Beeghly et al. 2003). They also have less access to financial and emotional resources and are more likely to have experienced discrimination (Surkan et al. 2006).

African-American women are also more likely to be depressed because of medical conditions or complications following delivery, including hypertension, infection, blood loss, and recovery from surgery (Field et al. 2009). They might experience loneliness and abandonment, financial difficulties, employment concerns, and lack of social support from partner. All these psychosocial stressors increase the risks of developing fatigue, poor motivation, and postnatal depression.

Care of the Infant

Feeding

In this respect there is an interaction between cultural, socioeconomic, and other influences on "how is the baby going to be fed." Middle-class African-American mothers breastfeed their baby at similar rates than other women in the United States. However, those of lower socioeconomical status have much lower rates of breastfeeding (Pak-Gorstein et al. 2009). The rate is only 50% for the newborn and low persistence over time (Sharps et al. 2003). This is particularly true if they are unmarried, younger, and in higher levels of stress. Also, there are multiple cultural barriers to breastfeeding. Many young women have never been exposed to seeing other women actually feeding a baby at the breast. Many women associate breastfeeding with pain and negative effects on the figure. A further barrier is the attitude of father of the baby toward breastfeeding, as well as belief in the importance of independence of the new mother and the child. Many mothers associate breastfeeding with the baby becoming spoiled, having to be carried a lot more, and "weak." The values mentioned of survival and self-reliance seem to be an adaptation to cope with higher chronic socioeconomical and psychological stress.

Even if the young mother initiates breastfeeding, continuation of breastfeeding for over 3 months is much more difficult, and it has a low frequency among African-American families.

The general rates for breastfeeding are approximately 59% initiation rate and 30% continuation rate at 6 months postpartum. This is very low in comparison with other groups and less than optimal (Centers for Disease Control and Prevention (CDC) 2013). Grandmothers, fathers, aunts, sisters, cousins, and friends influence infant-feeding decisions, including whether they will initiate and continue breastfeeding (Avery et al. 2009), although the decision to breastfeed or use formula is ultimately of the mothers (Cricco-Lizza 2004; Rempel 2004). Women inform their decision about breastfeeding based on their own experiences and what she has observed as a child or young woman (Asiodu et al. 2015).

Sleeping Arrangements

Indeed, co-sleeping is more frequently practiced among African-American families in comparison to Euro-American ones (Gaydos et al. 2015), up to four times more frequently (Joyner et al. 2010). This arrangement extends to the preschool years (Milan et al. 2007). It may also involve co-sleeping with siblings. It has been suggested that this might be related to the transgenerational effect of having to rely on siblings (Milan et al. 2007). If parent–child separations were frequent, parents might reinforce a stronger bond between the siblings,

who were less often torn apart. Despite all the warnings in the United States about sharing the bed with the baby, parents find it more convenient. There may be reasons of space and the need to use other rooms for other needs, as well as the wish to keep a close vigilance on the baby during the night.

Hair and Skin Tone

In most families in the world, when a baby is born, parents usually want to know whether the child is healthy, and the interveners usually reveal (or confirm) that the baby is a boy or a girl. After this, in different cultures other questions arise, for example the amount of hair, the weight, the color of the eyes, who the baby looks like, etc. In many African-American families, the quality of the hair and the skin tone are important considerations. Parents often refer to "good hair" as a hair that is not as curly or is straight or less "kinky." This seems to be related to the perception of the acceptability of the hair later on in life. Many African-Americans use hair products and attend salons to straighten the hair. When the child is small, the care of the hair is an important element of parental involvement. If the baby or child has a "hairdo," this generally reflects pride in the baby and care on the part of parents. The braiding of the hair can start as young as 6 months (Bellinger 2007). The hair of African-Americans was referred to by slave owners as "wool," and through generations, children were taught not to like their hair or that "nappy hair" was shameful.

A second consideration is skin tone. Like in most cultures in the world perhaps outside Africa itself, a lighter tone is "preferred." Parents might consider more beautiful a baby, particularly a girl, who has lighter skin, which will make her more attractive later on. If the baby is "too dark," parents might worry about the desirability or acceptability of that child. In groups of siblings, at times there is jealousy or a fear of parental preference for the lighter-skinned child. Later on in life, it seems that darker children tend to experience more harshness even from teachers, including darker-skinned girls (Hannon et al. 2013). This phenomenon has been called "colorism," and the empirical evidence available suggests that the tone of the skin predicts worse outcomes for those with darker skin, including social outcomes such as income level (Hunter 2002), wages in a given job (Goldsmith et al. 2006), educational achievement overall (Loury 2009), the self-esteem of the person (Keith 2009), and even the likelihood of getting married (Hamilton et al. 2009), among others, including the likelihood of getting the death penalty (Eberhardt et al. 2006).

Child-Rearing Strategies with Young Children

Parenting Beliefs

Several studies have revealed that many parents in the United States in general believe that an infant less than 1 year of age can be "spoiled" (Burchinal et al. 2010). This means that the child can be thought to intentionally misbehave to "get his or her way" or to control the parents' behavior. This belief is more prevalent in African-American mothers, who then may apply the corresponding discipline to prevent this willful negative behavior. Authoritarian parenting beliefs are represented well in all groups but are more prevalent in these families also (Bugental and Happaney 2004). It is hypothesized that parents want to instill obedience in order to protect their child from problems in the future, as they go out into the world.

When it comes to preschool children, parents of low socioeconomical background in general tend to use more physical punishment than parents of higher socioeconomical status, as well as harsher methods in general. A recent study comparing practices with preschool children found that African-American mothers generally did not allow much expression of anger or negative emotions in the child. Signs of "weakness" such as whining and showing fear were less tolerated (Nelson et al. 2012). For the outside observer, it may seem that many African-American parents are overly strict with young children, even of pre-

school age. This may result in more prevalence of insecure attachment style (Bakermans-Kranenburg et al. 2004). Parents may resort to scolding, yelling, or spankings, as well as using the belt from time to time. Mothers often explain that they have to be very intense in their discipline methods for fear that their child will "end up in jail." Many children perceive their mother "whooping them" or spanking them as a manifestation of caring and love, although undoubtedly there are many other emotional reactions as well. Some researchers have referred to a protective effect of physical discipline in African-American children (Deater-Deckard et al. 2005); in terms of less emotional difficulties later on in life, this does not apply to child abuse or neglect, however (Deater-Deckard et al. 1996). Indeed, compared with other segments of the population, the odds that an African-American boy may end up in jail by age 18 are much higher than for other ethnic groups in the United States (Burris-Kitchen and Burris 2011). This has been called the "criminalization" of youth or a "pipeline" of harsh discipline in schools to incarceration. All of this is strongly related to segregation, discrimination, and racism in schools, courts, and the society at large.

Interactions with the Health-Care System

There is a lack of trust for the providers at all levels in the health-care system. It leads to lower detection of depression in african-american women due to reduction in help-seeking behaviors and opportunities to talk about depressive symptoms (O'Mahony and Donnelly 2010). Women are also more likely to blame themselves for developing depression, due to stigma and shame associated with having mental illness. There are barriers related to access to perinatal care in general and mental health services in particular. Screening for presence of postnatal depression is not conducted regularly during the prenatal visits, and African-American women are less likely to receive psychoeducation about symptoms of this condition during every prenatal visit or infant wellness visits.

Stigma of Mental Illness

In low-income African-American women, there is increased reluctance to engage in mental health services. Stigma affects negatively the treatment-seeking behaviors for mental health needs during pregnancy (Nadeem et al. 2007). One of the greatest fears during perinatal period, is to be deemed "crazy," "unable to take care of her newborn baby," and "newborn baby taken away by the state" (Nadeem et al. 2007). Feinberg et al. (2009) reported fear of losing their child is exacerbated due to poverty and low social economic status and the prejudices of the child protective system. It has been suggested that women may not seek out treatment, as culturally they need to be "a strong Black woman" and have a "tough-it-out" attitude during pregnancy and postpartum period (Beauboeuf-Lafontant 2009). Many women may believe that depression can be treated by pure strength and religious faith (Nicolaidis et al. 2010). The evidence suggests that women who are very religious are less likely to seek mental health treatment from the medicalized health system and also may seek help from church or family.

Believing in the need of being a "strong woman/mother," African-American women may tend to minimize mental illness symptoms, stressors, and willingness to accept treatment recommendations.

When depressed during perinatal period, African-American women report more somatic symptoms than mood symptoms (Nadeem et al. 2009). There is also a more negative perception of mental health services. Often, women believe that the mental health professionals would more likely prescribe medications or hospitalize them than to use psychotherapeutic methods. As in most other traditional cultures, there is much fear of the use of any psychotropic medications during pregnancy and the postpartum stage. Generally, there is not a very high opinion of psychotherapy either (Lara-Cinisomo et al. 2014; Nadeem et al. 2009).

Many clinicians do not have much training or experience to have conversation with African-American families regarding issues of psychotropic medications or the efficacy of those medicines and psychotherapy. The clinician may need to be sensitive to the biases against these approaches (Marcus et al. 2001) and start treatment by developing a therapeutic alliance and discussing the person's own theories of the reasons for their problems and symptoms. Only when a relationship of trust is established, other possibilities can be introduced.

There is an unspoken and extraofficial form of discrimination in terms of quality of services, duration of interventions, and segregation in certain places (Porter and Barbee 2004). This includes not only overt discrimination but the chronic stress of daily micro-stressors or micro-aggressions. For example, being made to wait, passed over, or received with less enthusiam in clinics by the health care providers.

The mental health professional would be more acceptable if he or she were embedded in a medical setting, e.g., in an obstetric service. This would prevent the need to make a separate referral to a mental health center or facility. These centers are often overwhelmed in the public sector. They may have a complex intake process and then, if required, a consultation with a mental health professional. These centers also carry the stigma of being "mental health." If the mental health professional is a part of the medical services, this might reduce the fear of being labeled, stigmatized, or forced into treatment.

The questioning of the patient or family should be subtle, and it may take considerably more time to address topics such as discipline, parental beliefs, and history of violence, as well as use of drugs during pregnancy. Many women fear, with justification, to be automatically referred to Child Protective Services. These services are often overloaded, and there is little control anyone can exert over their determinations. Their intervention, although at times is necessary, is often an adversarial one. It is not perceived as a supportive service but perhaps as an enemy to be avoided at all costs.

The clinician should attempt to see the strengths of families who have survived poverty, living in violent environments often, and with little opportunity to afford education and many other services. A "strengths perspective" that takes into account the context in which the woman or family has evolved could attempt to understand their point of view, mistrust, and misgivings about any intervention.

Involvement by community leaders, pastors, and other community figures should be welcome in developing partnerships to detect and support interventions that are sensitive to the concerns and fears of future parents.

Much remains to be understood and studied about the different Afro-American communities in their specific circumstances and historical development. Also, much remains to be done to remedy ancestral inequalities which have transgenerational effects that are still with us today.

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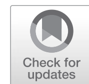

7 Working with Euro-American Families in the United States During the Perinatal Period and Early Childhood

J. Martin Maldonado-Duran and Clara Aisenstein

What Are Euro-American Families?

We restrict our description of the common issues for families of European descent to the United States because of our greater familiarity with the issues faced by families in this area. Also, given the enormous variability in countries and cultures between England, Rumania, Russia, and Italy or Spain, it would make a description very difficult to include these populations in other contexts, as there are considerable differences in the transition to parenthood, parenting beliefs, health practices, and attitudes toward young children in each context, which would make a description less useful. However, many of the values and beliefs are applicable to families of European descent in other areas of the world.

Even saying "Euro-American" families is complicated, because a country like the United States also has much intrinsic diversity even in families that commonly are considered as "white" or Caucasian. Obviously, Euro-American denotes in principle families whose ancestors migrated to the United States from many countries, and the differences between families of Italian, Irish, German, Croatian, Russian, and Spanish descent could also be very large. The United States has been a country of immigrants (who took over the land from the Native Americans), and the coexistence of families from different heritages has been valued to a large degree.

We will focus our description to families that tend to be the dominant groups in the definition of being "Caucasian," i.e., families of Anglo-Saxon, German, Dutch, Scandinavian, and generally Northern European origin. Many families whose ancestors originated from other European countries have tended to "assimilate" to a considerable degree in what used to be called the "melting pot" of America, such as families of Polish and other Eastern European countries.

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The Influence of the United States: A Transcultural View

Another reason for a description of Euro-American beliefs and practices is the enormous influence that the scientific production and publications from the United States have in many other areas of the world. This view is important as in several areas of the world, the publications and research methods described in the United States are eagerly copied, adapted, and seen as "more advanced," more modern, scientific, or based on empirical evidence; and this is widely seen as an advantage. Many American publications are

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translated to languages like Spanish, French, or Italian. The public in those other countries, as well as health professionals, often assume that the recommendations that might be applicable, or even valuable, in the context of the United States are equally valid and meaningful in a rural town in Mexico or Argentina. This may or may not be so, but it is important to keep a perspective as to where information is originated, what is the scientific basis for it, its cultural context, and whether it could be applicable or useful in other contexts.

In this chapter we take a "transcultural view" of the most common beliefs and practices commonly seen in parents during the perinatal and early childhood stage and describe them "from outside." The authors, as immigrants, may be able to approach ideas, beliefs, and caregiving strategies that for a native person might seem as "natural" or ideal, but which may look very artificial and even strange for someone "from outside."

An example might be the use of "time-outs" with young (and older) children. Time-outs were essentially unknown in Latin America even 30 years ago. The influence of many parenting books from the United States which have been translated to Spanish has made the "adoption of time-outs" (and in fact under that very English name, without translation) a recommended and respectable practice among pediatricians, and well-informed mental health professionals, who may recommend them to the families with whom they work. As a "distancing" disciplinary technique, it was never a part of the "Latino" cultures wherein it seems strange to put a child in a special seat, a corner, or a room and "count minutes" (the standard recommendation being 1 min per year of age) and think that this is a more useful, humane, or efficacious disciplinary strategy, adopted as scientifically determined and of proven value. In reality, there is no conclusive evidence that "time-outs" should be extrapolated to other cultures in dealing with young (or older) children's transgressions; critical appreciation dictates that they are artificial (e.g., the notion of 1 min per year of age), and young children of course do not have a notion of what 3 minutes is, as opposed to 4 minutes. Time-outs indeed might be very scary to children, particularly in a culture in which children are always close to their caregivers and are never ignored on purpose. In a culture where discipline consists of depending on an adult to regulate one's emotions, the "distancing" strategy might provoke particular anxiety and be seen as very threatening by a young child.

Even in the United States there is some evidence that for some children it produces considerable stress to be ignored by one's parents or caregivers, and the mere threat of the time-out is also stressful. The same could be said about the notion of "counting 1, 2, 3" which is recommended in a number of parenting books (Phelan 2016) as a "warning" for children to comply lest they receive a "consequence" or punishment and which also puts parents in a threatening stance. There are multiple other practices that have been "imported" by parents from other cultures and which may or may not be useful, applicable, or helpful to the families, but are transplanted without much consideration about how they fit within the wider cultural context.

Something similar could be said about the "modern practice" of never allowing babies to sleep with their parents, nor toddlers or preschool children. Co-sleeping has been characterized as quite common in German families (Valentin 2005) and has been a common practice in Latin America (and almost the rest of the world) for centuries. If parents follow the advice of pediatricians and mental health professionals steeped in the "American" practices, they would be advised against this practice. In this scenario parents might be in a contradictory position: their own experience as children, and their relationship with their young child, leans in the direction of sleeping with the child, but it is contradicted by the "advice of experts." The advice might have been adopted in the local country without much exploration as to the scientific basis for the recommendation, but merely because it is held strongly in the influential area of the world, the United States. We will also highlight some of those conflicts and practices here.

What Is "Whiteness"?

In the United States there is considerable interest in ethnicity and in "race." The concept of race is not entertained anymore in many countries as it is considered unsupported by science. Generally, "race" is defined according to physical criteria (such as "skin color"), while ethnicity is defined in terms of uniformity based on cultural factors (Lee 1993). However, in many parts of the United States there is a clear distinction between "African-American," "Hispanic American," or "Chinese American," to name a few. In official documents, it is not uncommon to ask a person who is registering, about their race and ethnicity, with the options being Caucasian, Hispanic, African-American, etc. Even when ethnically speaking people of "Arian" descent should be considered as "white," in the United States they are not, such as people from India or Pakistan. Also, most of the public in the United States would not consider people from the Middle East as "white." The country has a long history of racism that only ended officially in the decade of the 1960s. However, for people from older generations there might be a great value still to concepts like racial purity, not mixing "of races" (there were laws forbidding the marriage between a "white person" and a non-white one until several decades ago) and maintaining their unique status (Sollors 2000). In the last decade, racism and "white supremacy" has become much more open and acceptable for many people—even beyond the United States.

It is also common for people who are asked their ethnicity, to say that they have a proportion of British, Irish, German, etc. One might say "I am a quarter each of British, Irish, German and French." Incidentally, it could be mentioned that the racial laws that were already in the books in the South of the United States in the 1930s were a model for the Nazi regime to promulgate the "racial laws" against Jews and the "non-Aryans." Those Southern laws were primarily directed to classify the "degree of whiteness" or "blackness" of people or to determine if they were "colored." They went so far as to classify a person with a "sixteenth of black blood" as "Negro." As a matter of fact, there were laws that were referred to as "one-drop rule" (Khanna 2010), meaning the slightest ancestry of "blackness" defined the person as Negro (Roth 2005).

A distinction is informally made in the popular culture between middle-class Caucasian families and the "white poor" (Wray 2006), who may be referred by derogatory terms such as "trailer trash" or "white trash " and are considered by the predominant "white middle class" as less educated, chronically poor, dependent on public assistance to some degree, and less acceptable in the "mainstream" (Hartigan 2005); despite their race and ethnicity as "white/Caucasian" they are discriminated against or feared (Lister 2015). The term "white trash" is also used in Australia for the "white underclass." In fact, a family might devote much attention and energy to avoid appearing in such way that might be mistaken as "trailer trash" or "hillbilly" (i.e., coarse and less refined). Such families tend to have child-rearing practices and acceptance of dependency that are not common in middle- and upper-class Caucasian families (Abbott 1992).

Common Concerns of Euro-American Parents During the Perinatal Period

The Mother

There has been a striking change in the role of women in general, in terms of their role in the family. Many have joined the workforce and will be expected to work often up to the end of the pregnancy and then perhaps a few weeks (often 6 weeks) after the delivery of the baby. There is scarce information as to what these changes mean for them in terms of their psychic life or facing the prospect of being a "full-time mother." Many new mothers fear the arrival of the time of separation from the baby at 6 weeks of age and finding alternatives to the care of the baby. This could comprehend family members, a formalized child care center, or a more informal acquaintance that may care for the baby privately with or without payment.

It must be mentioned that for many women, particularly those in economic hardship, such work outside the home is not optional, but necessary. Other women may choose to work because of their values, having a career, sharing in satisfying the economic needs of the family. In other cultural groups women may work strenuously, but more often at home and looking after children, cooking, in agricultural activities, selling things, etc.

An important distinction when one discusses "work" during pregnancy is the nature of such work. A factory worker who has to stand all day long during pregnancy may have a very different experience of the pregnancy from a woman who works in an office, where she can sit. There is some evidence that long hours of work, particularly if they involve lifting heavy objects, standing a lot, high noise levels, changing shifts, working in a night shift, and high level of stress on the job, can lead to a higher risk of having a small for gestational age newborn. This is more likely if the woman has also low psychosocial support (Croteau et al. 2006). The evidence is fairly consistent regarding the more strenuous working conditions (Escribà-Agüir et al. 2001).

There is much debate in the scientific literature regarding the effects of long hours of child care by workers in a formal child-care center. Some research shows it does not lead to alterations in the attachment pattern of the baby, while other studies show more insecurity in the attachment. In any case, the quality of the child care in the United States leaves much to be desired. The "business" of child care is often neither seen as a profession (which requires a minimum of education in child development) nor a vocation requiring knowledge of the emotional life of infants and young children. As a result, it appears that spending long hours each day of the first few years of life in child care (as opposed to maternal care) puts the child at higher risk of developing externalizing behaviors, such as more hyperactive and aggressive behavior (National Institute of Child Health and Human Development Early Child Care Research Network 2003).

The Father

Both expectant mothers and fathers worry about similar issues, but several research projects have shown that women and men worry to a degree about some issues differently. Men tend to worry more about financial issues, about material needs, and about the safety of the baby in the future (Biehle and Mickelson 2011). Men face a new role in the family that in previous generations was fulfilled by extended family. In a small nuclear family, without the support of other women, the husband/future father becomes the main source of emotional sustenance for his wife/partner. This "new" role is embraced by many men; it includes a more intimate relationship with his wife, and also with the baby, changing diapers, feeding the baby, and helping the baby go to sleep. However, this role is very challenging for many new fathers. They may not know how to respond to the expectations of offering emotional support, listening to his partner, dealing with emotions, etc., and the role may make him feel very distressed or with less freedom than he expected (Maldonado-Duran and Lecannelier 2008). Many men are not socialized to speak of emotions, deal with unpleasant ones such as sadness or fear, and may feel at a loss as to how to respond to a partner who expects to be able to discuss internal states.

The Baby

Parents generally place more emphasis on the baby being healthy and strong, rather than on the gender, and there is no strong and open bias toward having boys. Most fathers would say it is equally valuable to have a girl or a boy, although there may be an unspoken bias toward male pride and passing one's values, admiring strength, valor, and persistence as well as self-reliance.

Mothers might proudly show pictures of their baby, and the parents might say they have the "most beautiful baby in the world" or say that the baby is "perfect." This would not be said by parents in many traditional cultures, where it would be considered bragging and somewhat dangerous

to boast about the positive features of one's baby, as this might elicit feelings of envy in other adults, which might have a negative effect on the infant. Actually, more Westernized parents are not really boasting, but simply saying "he is the most beautiful baby in the world…to me", or in my eyes, or just meaning that they love their child very much.

In general, malformations and severe or chronic medical conditions are deemed to be anchored in genes and biological phenomena, and most parents would take an accepting attitude toward a baby who shows a dysmorphic condition or a severe disease, and they would treat the baby with love and affection and show the baby to relatives and friends without shame, as these characteristics are not thought to be a reflection of something negative about the whole family.

Parenting Strategies, Beliefs, and Expert Advice

Many Euro-American young parents are eager to acquire information about the "best possible" strategies for raising their child and to promote the growth and development of a healthy, intelligent, independent, self-assured, and friendly child. Generally, they hope he or she would acquire early on academic skills and learn many things as soon as possible. Also, much has been written about the issue of independence and "self-reliance" of the child, according to the predominant ideology of the "rugged individualism" that is more stringently employed with boys than girls. There is an intriguing question: how much of the above might apply to parents living in poverty? After all, the United Sates despite being the wealthiest country in the world has relatively high rates of poverty, even for Euro-American or "white families," around 10% of the population (for Latino and Afro-Afro-American children the rate is several times higher). It seems clear that the more financial stressors a family faces, pressures to pay rent, to acquire food, and to pay multiple bills, the family might embrace more traditional values, such as living with other relatives in order to share the expenses of the household and allowing more "dependence" by their children.

In the United States the mainstream parenting advice has changed considerably in the last decades. Not long ago, authors like Ferber (2006) and others recommended to not pick up and cuddle even very young infants if they woke up and cried during the night, and this advice has now changed to a degree, even by the same author. In fact, the American Academy of Pediatrics used to recommend that the baby sleep in a separate room from that of the parents, even as a newborn, and this was changed a few years ago, now recommending that the very young infant sleep in the same room. There are even new approaches to parenting that advice to consider a long-term perspective in the emotional development of the child, more sensitivity to the emotional life of the child (Lieberman 2018), and developing more sensitive strategies to deal with the baby (Siegel and Hartzell 2014).

However, there are still many authors who emphasize a mostly behavioristic point of view in parenting, that is, eliminating or extinguishing undesirable or problematic behaviors and substituting them for more self-reliant and acceptable ones by the infant, toddler, or preschool child. The emphasis in these behavioral protocols is on short-term results, focusing only on the actual end result. Often, these programs emphasize compliance, obedience, and respect for authority figures. Generally, they take a "uniform view of children," i.e., as if all the children were the same, and therefore one can generalize one strategy to fit all children of that age. They tend not to do much justice to the individual style of each child, their temperament, sensitivities, and emotional life. Temper outburst, disobedience, noncompliance, etc., are generally seen as a problem that must be eliminated, focusing on the needs of the parents and not thinking much of the child's point of view. This advice is often embraced by well-meaning pediatricians, who are often asked for parental advice. Most pediatricians in the United States are generally rushed to spend only a few minutes with each child/family, and this maximizes the need to give "standard answers" to

parental requests for help such as how to deal with temper outbursts in a toddler. A common advice is that parents should ignore the child not to give attention to the undesired behavior, and then it will disappear. There is no time to inquire about the nature of the tantrums or what they might mean.

Another common theme is that the child should have "natural consequences" for their misbehavior and generally willful or aggressive acts should be followed by a punishment or a "consequence." There is little thought as to why the child might disobey and not comply or what might be the emotional response to a regime of being ignored or punished consistently.

Regarding the issue of sleep, most sleep experts in the United States recommend to teach children as early as possible (e.g., from the newborn stage) to "go to sleep by themselves," i.e., without intervention from parents, and to learn to go back to sleep without requiring adult intervention so that caregivers can also sleep uninterrupted through the night. The question of whether a toddler is afraid, has experienced a stressor, or was scared by something is not given much attention.

Time-outs as a disciplinary strategy are now starting to disappear as a standard practice among a segment of the population. However, many parents, family doctors, and even family physicians and pediatricians recommend them as an effective discipline strategy, generally advising to give 1 minute of time-out per year of age.

Also, many pediatricians endorse spanking "in certain circumstances" as a perfectly appropriate or even desirable response to some infractions, even though it has been officially banned by law in many countries, as a form of abuse of strength toward another human being.

In contrast to the practice in traditional societies, where elders may have much advice to impart on child-rearing strategies, in more modern countries parents often turn to "experts" (e.g., parenting books, websites, etc.) in order to learn about how to deal with issues like feeding the baby, managing sleep, discipline, and for parenting advice in general.

The predominant structure and functioning of families in many sectors of the United States is nuclear and composed mostly of the parents and two or three children. There is generally little opportunity to interact with grandparents, aunts and uncles, cousins, etc.

A young woman who just had a baby might receive the visit of her mother for a short period and then deal with the child by herself with the assistance of a manual, books, and websites. Also, many young parents have not seen "first-hand" activities like breastfeeding, feeding a toddler, dealing with sleep issues, soothing a baby, changing diapers, etc., because of the diminished opportunity to interact with family members in different stages of child development, or of family life, which is a common occurrence in extended families or family networks in traditional cultures. This form of knowledge is referred to as "experiential learning," as opposed to "acquired learning" (Ryan et al. 2001).

Feeding the Young Child

Several decades ago breastfeeding an infant on demand was considered "unscientific" and unpredictable, as parents could not quantify how much milk the baby had ingested. Experts used to recommend feeding the baby a bottle of milk formula on a schedule, e.g., every 3 h. This was a sort of "medicalization" of an area that had been left to mothers' intuition for centuries. This advice has changed; now most pediatricians recommend feeding the infant on demand, and the general recommendation is to at least attempt breastfeeding. Still, many mothers with work demands have to carry out multiple arrangements to be able to continue to feed the baby breast milk and many resort to formulas. In many hospitals, it was common for nurses and other healthcare staff to start feeding the baby artificial milk and to offer a "gift" of a supply of formula to go home. The commercial powder milk often was supplied by the baby formula companies, in hopes that the baby would continue to be fed with their particular brand, having started in the hospital. In the "baby-friendly hospitals" this is not happening,

but it is common for healthcare staff not to be trained on strategies to promote breastfeeding and to quickly recommend bottle feeding to mothers who are experiencing difficulties with breastfeeding (DiGirolamo et al. 2003). Fathers still are not always supportive of the practice, which is often discouraged "in public," as mothers have to go to a restroom or other private place in a shopping mall to breastfeed the baby. Some members of the public experience disgust and uneasiness if a mother is breastfeeding near them, as the breast is seen at least in part as a sexual organ and not primarily as a feeding one. Many mothers start breastfeeding and have to give it up at 1 year of age of the baby, as many healthcare professionals and the public might experience reservations to prolong it to the second or third year of life (Maldonado-Duran et al. 2004).

Parents of older babies are encouraged to let the child start feeding himself at around 10 months or so. Many infants are "fed" by their parents at a separate time, without the opportunity of a "family meal." In fact, eating meals as a family is vanishing as parents are very busy and the feeding situation is often seen mostly as a matter of calories and nutrients and not as much as a social exchange.

Some feeding experts have recommended a number of "feeding rules" that are thought to promote optimal nutrition: to adhere to a schedule, to not play with children during the mealtime but to devote it to eating first and foremost, and to not prolong the meals beyond a specified time, which could be 20 or 30 min. With preschool children many families have additional rules, such as "cleaning the plate," i.e., eating everything that is served, or "trying one bite or two of each item," even if the young child says he or she does not like it. In many preschools and child care settings, the mealtime is also full of rules: the child has to feed himself at all costs, and teachers and other caregivers might frown if an adult tried to spoon feed a healthy child who is not eating on his own devices (spoon-feeding is a practice that is common in many other cultures for children at this age). Children are expected to stay sitting during the meal, and often they cannot have "seconds" of any item until they have finished everything on their plate. Children cannot play during the meal, and all the children have to finish by a certain time limit, after which the food is discarded. There is little opportunity to accommodate a child who is slower or more sensitive to textures, flavors, and odors or one that likes to sing or talk during meals or play with the food and eat it at the same time. The general notion is that the adults are in control of the feeding situation, and the child has to adjust to these rules.

Sleeping Issues

Parents are encouraged by healthcare professionals and many experts to never sleep in the same bed with their newborn and with young children in general. The concern about young infants is the issue of sudden infant death and the fear of "rolling over the baby." This is the standard advice. If parents insist or desire to have a "family bed" or co-sleeping, they might not tell their doctor or only "confess" to that with difficulty (Jenni et al. 2005). There are a number of recommendations to practice co-sleeping safely, which include that the adults not to use drugs or alcohol and to have the baby sleep on a firm surface, without pillows and soft toys and without blankets.

Parents often feel guilty if they follow their intuitive inclination to allow the baby to sleep with them and even more so for preschool-aged children. Several surveys have shown that a majority of preschool children spend part of the night in their parents' bed, and many parents, mostly due to exhaustion, allow this, against their own stated opinion or expert advice, simply because they feel it is not worth fighting with a preschooler who may be scared or unable to go back to sleep alone in the middle of the night.

Several experts have also suggested a number of "rules" to promote that the very young child learn to sleep by him- or herself or "put himself to sleep" without or with minimal parental intervention. For instance, it is often recommended never to allow a baby to fall asleep while he or she is being "rocked in the parent's arms." The standard advice is to put the baby on his or her

bed while still awake and then allow the child to fall asleep on his own, even if the baby cries briefly. Still, many experts (Mindell and Owens 2015) who are very influential advocate strongly not to intervene when a young child wakes up in the night crying, after making sure the baby is not ill or in danger in some form. Nevertheless, the infant generally has an instinctive bias toward wanting to sleep with his parents. The baby may "insist" on co-sleeping despite all this expert advice. As a toddler, the child who wakes up during the night may be able to climb over the side of the crib and go to the parents' bed. Against this, some experts have suggested to purchase a device to cover the top of the crib so that the child is "securely ensconced" inside the crib, is unable to leave, and eventually will go back to sleep on his or her own. This advice ignores the fact that many parents may not feel comfortable to not respond to the "distress signals" of the baby (i.e., crying) and another issue is that many children get extremely upset, becoming cyanotic while crying intensely and for long periods of time, or may vomit on the bed due to the crying. Aside from these considerations, many parents may feel guilty that they are "giving in" to what is perceived as a willful child. Fortunately other experts (Minde 2002) advice a more empathic approach and recommend to consider the emotional experience of a child whose parents "ignore" them, even if the infant is very young. They recommend to reflect on what the child might be feeling or telling them with the "undesirable behavior." The suggestion is to change the parental behavior more gradually rather than "ignoring" the crying. Others advice to co-sleep with the child (McKenna and McDade 2005).

Sleep in many preschools and child care centers is another important concern. In many of these centers, there are actual regulations that the staff has to offer a "naptime" or quiet time for the young child, which may last even 2 h in the middle of the day. While many preschoolers might require a nap, others do not, and 2 h is a rather long nap. As a consequence, many children will experience difficulties going to sleep at night. Others will have difficulty to fall asleep in the middle of the day. The staff generally insists that the child go to sleep or at least to stay on a cot, lying down, without making noises. This is very difficult to achieve for many children. Instead of an opportunity for the child who needs the nap, the uniform rules involve generally all the children and this creates difficulties with behavior and sleep onset problems in the night.

Fostering Self-Esteem and a Competitive Attitude

In the home environment and preschools there is a considerable emphasis on individual achievement and on making an effort to accomplish what one wants. For instance, preschool teachers would insist the children "pick up their toys" after playing with them and would enforce this expectation. The notion is that they would feel pride in "cleaning after themselves" and learn responsibility and accountability for their actions. Then they can feel proud of themselves.

There is generally an emphasis on competitiveness and "winning" and individual accomplishment in homes and in the preschool environment. Teachers may reward children by privileges like "being first in the line for lunch" or "being the leader" for a day. Generally teachers praise children for their individual accomplishments. This is in contrast with traditional cultures in which winning is not emphasized and a person might be embarrassed to be pointed out as "the winner," as no one should be above the others (Bolin 2006), or the child does not act as a sole agent, but a part of a group, who accomplishes things in the company of others. The emphasis on having a "winning attitude" or a "winner temperament" may be reinforced by some parents all through childhood.

The Advent of Electronic Technology

This is actually an issue for all parents of all backgrounds in technologically advanced societies. There is a proliferation of devices to do many things that were not possible before. Monitors

with cameras and microphones to observe the baby who may be sleeping in another room. Also "breathing bears," i.e., teddy bears which make the sound of breathing or a heartbeat to calm the baby. There are all sorts of toys that move, make music, talk, read stories, and move the crib as though it were a parent moving it. Some of these might provide relief to very tired and stressed parents and give some respite to them. At times they are used as a substitute for parents, or as the main "company" of the child for multiple reasons, so the substitutes may get in the way of person to person contact.

Other devices are perhaps more negative in the life of infants, such as smartphones, touch tablets, and others that distract mothers and fathers from interacting directly with the child. Increasingly one comes across parents that are "connected all the time" to some device and "multitask" between being with their baby and posting things, texting, and conversing with other people instead of focusing just on the infant.

With increasing frequency, parents of older infants introduce the tablets and smartphone to "teach the child" things like letters, colors, etc., and to view videotapes of cartoons, lullabies, and movies incessantly (Steiner-Adair 2013). It is uncertain what the effect of these devices is, particularly on the parent–child relationship. An experienced pediatrician was alarmed after making this observation:

> When I go to the park and observe mothers and young children, I increasingly see mothers pushing the swing mechanically, without looking at the child, but "multitasking", and viewing their cellphone, checking their Facebook, uploading pictures, texting or keeping in contact with friends while swinging the young child…I worry about this trend…

Thanks in part to the influence of B. Brazelton, the American Academy of Pediatrics recommends not to use any "screens" with infants at least in the first 2 years of life (American Academy of Pediatrics 2011). Despite this, they are increasingly an object that comes between parents and infants' direct interactions. This policy also advises against parents using these devices in the presence of those infants.

Schedules

The interest in schedules is an important feature in European American families in general. Many activities are regulated by a precise and predictable time when certain things will take place during the day, and generally parents are advised to adhere to these schedules consistently. While it may be that young children might benefit from having a routine, at times the schedule is adhered to in a rigid and concrete way by parents and child care providers. Many parents are very worried about the child's bedtime and feel it should be the same every day, concretely at a fixed time on the clock. The same might be for meals, playtime, baths, etc. Of course, many families in the "real world" cannot possibly keep such a schedule, but parents may feel it is inappropriate to change the routine in any way.

In many child care centers and preschools, this is taken to an extreme. Teachers may be expected to maintain a "teaching plan" that includes play activities, learning times, "circle time" (in which children may hear a story and have to sit on a fixed spot on the floor), as well as "free time," lunch, etc. Sometimes the schedules are strangely precise, such as "10:32 to 10:47" work on one "activity center" and "10:48 to 11:17" time to learn in a different center. Sometimes a child who is engrossed in one activity in one center has to switch suddenly because of the neutrality of the clock or timer. Some children protest vigorously insisting that they want to finish a drawing or making a castle, etc., but they have to learn to comply with the "structure" of the setting which is adhered to rigidly. This is often referred to as "dealing with transitions," which are not natural but dictated by the clock. The adherence to rules seems very important in comparison with other preschool educational systems as shown in a study comparing preschools in the United States with Finland and Russia (Hujala-Huttunen 1996). Children who insist on doing what they started to do may be said to have "difficulty with transitions" or to be noncompliant, and parents may be advised that there is a problem with transitions or that their child is "defiant". Obviously, these schedules are impossible to maintain in the "real

world" with absolute adherence to the specified times, but it is considered still as an "ideal" to structure the life of very young children to this degree. The mother of a preschooler who was particularly creative and wanted to finish a project wondered if this "regime" was a preparation to life as an adult in an office, a factory, or an assembly line in a capitalistic society.

Management of Discipline

Following rules, telling the truth, being "accountable for one's own actions," and obedience are common values for many European American families. In many families it is considered inappropriate for a preschool child to "question their parents" or to "talk back" to them or to teachers. Talking back generally means to question what an authority figure is saying, to say "no" to their instructions, or even sometimes to just ask for an explanation as to the order or request. This is generally discouraged. Many young children are considered "defiant" or oppositional because they protest and do not follow the instructions, ignore them, or persist on doing what they were doing or, even worse, if they actually say they will not do what is asked of them. Obedience is a very important virtue, as well as "following rules," which apply to everyone uniformly. This is enforced even with quite young children, who may be physically made to do what they are told or managed with a "behavioral modification program". Parents may be advised to take the child to a mental health professional the extinguish the disobedient tendency.

In many Anglo-Saxon protestant cultures (viz., in the United States), there is great emphasis on respecting the laws and obeying rules. There are many rules to be followed which govern the behavior in public, such as parks and public swimming pools, and sometimes in private. Often these rules are geared toward not bothering other people with one's problems and to protect the institutions against possible claims for damages or injuries. There are multiple possible penalties for infractions to these rules from admonitions, warnings, legal consequences, law suits, etc. Walking in the streets in a city can be governed by multiple rules about what is possible, and these rules are generally enforced. A foreign person, particularly from a less industrialized region, might be surprised by the abundance of rules in almost every sphere of life.

The reverence of rules seems to be a factor in parenting behavior. Parents are eager to teach their children to obey rules and to learn that "there are consequences" for not following them. Rules are "neutral" in the sense that they apply to everyone and do not depend on moods, a benevolent attitude on the part of the enforcer, or luck. Rules do not depend on anyone's state of mind or moods, and they do not require complex thinking and apply equally; at least that is the ideal. As a result, caregivers often give consequences even to young children who failed to obey certain rule, at home and in child care centers and preschools.

Beside "consequences," another basic moral principle is the worry about "getting away with a transgression" that might go unpunished. In most parenting books caregivers are encouraged to be consistent and not to vary in their respect for rules and application of consequences. It is believed that only in this fashion children will learn from their mistakes and improve their behavior. This ideal is often impossible to practice with children who are very impulsive, who do not think ahead of acting, or who are angry and deliberately break rules they know well. Parents are at times entrapped in these sets of rules that they fear not to apply consistently, even if obviously the punishments are counterproductive. The belief in the necessity of punishments and their wisdom is almost unquestioned and is a part of their *Weltanschauung*, observable in all spheres of life. Sometimes adults are horrified not so much by the crime someone committed, but by the fact that the crime went unpunished, which is considered unfair.

One of the results is that much of the parenting and discipline is "reactive," i.e., consequences are applied by the breaking of rules and disobedience, tending to reinforce the "fear of punishment" as the reason to behave well, rather than the notion of doing good things because of their

inherent value. This could be called "external discipline" as it depends on "being caught doing the wrong thing" and not so much on an internal compass that would guide one's behavior for the "right reasons."

Telling the Truth

Even with very young children, parents hope to teach that it is very important to tell the truth, even if one might have to confess to a transgression or receive a negative consequence. Many parents consider it worse to lie about a transgression than the transgression itself. Later, in elementary school, children might be taught that "George Washington never told a lie" as an ideal to be emulated. This tends to lead to an honesty in expression and opinions that can be very refreshing and unexpected when viewed from outside, as children are expected to say what they "really think" and to express their feelings and thoughts openly. In many other cultures, children are encouraged to suppress self-expression for the sake of conformity and respect for elders. The frankness of statements at times can be offensive to people from other traditions, in which saying things like "I do not like this food, I don't want it" could be considered as an offense when in reality they are mere expression of telling the truth. It may be difficult for these parents to imagine living in places in which telling lies is adaptive, as it may help with survival, saving face, maintaining family prestige, or avoiding serious consequences, something which children may learn from very early on.

In the United States and many other industrialized countries, there are abundant parenting manuals designed to help parents to deal with discipline. In many of them the emphasis is on external undesirable behaviors and how to extinguish them ("talking back," noncompliance, being rude, temper outbursts, etc.) and less on understanding what might be underlying those attitudes, what emotions or reactions in the child might maintain them. Often, the disciplinary recommendations consist of an exclusionary technique or ignoring the child, such as "time-outs" (the parent assigns a place for the child to sit and does not interact with the child during the duration), sending children to their room, withdrawing of "privileges," or taking away desirable objects such as toys or electronic devices. These are considered much preferable to humiliating, embarrassing, scaring, or shaming children. Being ignored, however, is a highly artificial behavior that is equivalent to the withdrawal of attention, or love, which could be quite stressful for a young child. In any case, it does not address the question of "why the child is doing this" and focuses only its external manifestation. There is less interest in what is underlying the negative behavior and something is considered "effective" if it successfully eliminates it.

This applies not only to aggressive expressions but also to difficult emotions such as sadness or anguish. Young children, particularly boys, are often encouraged by parents and caregivers "not to cry" when they are dropped off at age 2 or 3 at a child care center or a preschool. Crying is considered difficult and it could bother other children. The child should make efforts to be brave and not to manifest the fear of strangers or missing the parent.

Additionally, the emphasis on promoting individualism has been called "the Anglo Saxon syndrome" by Bronfenbrenner (1992). In the situation described, arriving at preschool or child care center, the child is often afraid of strangers or worries that the mother or father is gone and might not come back. As long as the child does not cry, many teachers tend to consider the separation successful and the opposite if the child cries. A child might be extremely worried and afraid but realize he or she is not permitted to cry and "swallows" all his feelings, even though he is still very insecure and scared.

Sharing and Cooperating

Sharing of toys and other possessions is encouraged in most cultures at different ages. In the United States and other Westernized countries, children are only encouraged to share until they are more cognitively able to understand the

feelings of others and that other children might also want to play with a toy or touch something. In many traditional cultures, children are encouraged to share at a much younger age and parents expect it even at 1 or 2 years of age. The notion is that respect for the individual desires is secondary to the interpersonal harmony and being socially appropriate. Something similar can be seen on the issue of cooperation. In countries like Japan or China children are stimulated from a young age to cooperate with others and think of the welfare of the group, rather than what they individually want to do or wish. Young children are praised for showing kindness and thinking of others. In many Western cultures, each child is encouraged to do their own work and not to expect help or accept it as each person should have their own accomplishments.

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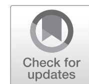

8 Working with Native American Families During the Perinatal Stage and Early Childhood

Clara Aisenstein and Anna Rueda

Introduction

There is a great diversity among "Native American," aboriginal groups, tribes, and communities. No sweeping generalizations are possible, and persons or families who define themselves as Native American may vary enormously in their beliefs and actions. There is diversity in languages, child-rearing practices, and goals in raising children (Sarche and Whitesell 2012). Here we refer to some themes or possible commonalities and issues that may arise frequently, which a clinician may need to take into account.

We emphasize how Native American families, who historically have been excluded from the "mainstream culture," may see the world differently and may attribute causality for complications or problems in pregnancy and early childhood. Often, there is an unconscious tendency to devalue Native American beliefs and practices and perceive them as "stuck in time," which may impede appreciating the resilience of families living under chronic transgenerational stress.

Native Americans or American Indians, like other groups all over the world, found themselves embedded in "foreign" ethnicities (when the colonization of the United States occurred) and were forced to acculturate to Western values, including religious ones. We attempt to explore how this history of segregation, and "cultural warfare" in the past, and discrimination/segregation in the present have impacted family functioning, the role of parents, and the children's experience of living within their culture and interfacing with other cultural groups.

The European invasion and the engulfment of Native Americans had a strong impact on the ecology, the philosophical and spiritual-religious values, and everyday practices within their tribes. The encroachment also had an impact on the child-rearing strategies that tribes had used for generations, family and community living styles, and the way indigenous people are related to each other. Something similar can be said about the aboriginal inhabitants in Canada and Australia and many other colonized or conquered groups.

Only some elements of the original cultures remain as a living document of the adaptive struggles for material and psychological or spiritual survival.

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What Is Native American?

The term gives the impression of uniformity to the multitude of diverse ethnicities and identities. There are 562 federally recognized tribes in the United States, yet there are still other groups with roots indigenous in United States, lands that remain unrecognized or disenfranchised (Barusch and Tenbarge 2004). Tribes are ethnically, culturally, and linguistically distinct and diverse (Limb et al. 2008). There were a total of 326 reservations in 2016. In 2015 Native Americans in the United States totaled 6.6 million people and comprised 2.0% of the population.

Since the beginning of the federal government, the Native people have occupied an alien enclave in their own country. In the 1830s the United States government developed a policy of Indian removal east of the Mississippi River, a large-scale removal of Native peoples from the areas that European Americans were settling, which was accomplished through treaties, coercion, and military force.

Reservations have been a fundamental aspect of Native American existence. For some, they are a living reminder of Euro-American colonialism and nation-building, while for others, reservations today are the last remaining stronghold of "sovereignty" and opportunity to preserve their original languages and traditions. As with many other peoples in the world, many Europeans considered Native Americans intellectually, emotionally, and culturally inferior, so their cultures were not worth preserving.

Historical Trauma

Maria Yellow Horse Brave Heart (2003) recognized the collective trauma or "colonization trauma" (Davis et al. 2014; Whitbeck et al. 2004) and emotional pain that has been linked to various traumatic effects: psychiatric metabolic illnesses (e.g., diabetes) (Tom-Orme 2000), alcoholism, and substance addictions among Native peoples.

There is evidence that the negative experiences that a woman endures during pregnancy produce negative "programming" effects on the baby in utero, which decades later lead to a greater epidemiological vulnerability to various chronic illnesses (Gravlee 2009). It also has been shown that these alterations can have a multigenerational effect (Lock 2011). It is theorized that those noxious events and their after effects contribute to the persistence and pervasive effect through generations (Duran 2006; Whitbeck et al. 2004; Brave Heart 2003). The official policies of the United States government included suppression of traditional practices that were culturally relevant, such as dances, the practice of healing rituals, and the traditional religion (Wiedman 2012), as well as the use of the native language in boarding schools. This has been described as a "cultural genocide" which is in the background of many of the adversities experienced by Native American families and children.

Native American Women and the Perinatal Stage

Prior to the strong European influence on Native Americans, in several tribes, particularly Southeastern ones (e.g., Seminole, Cherokee, Chocktaw, Chickasaw, and Muscogee), women were of equal standing to men and had the same power, and even some tribes were matriarchal e.g. Dine (Givens McGowan 2006). In those tribes, women controlled the agricultural production and the trade. The lines of inheritance were matrilineal and children "belonged" to the maternal clan. The residence was also matrilocal, and the husband went to live with the wife's family. Maternity was considered the most important role of women, above that of wife. Also, women had considerable sexual freedom and were able to have relations with whoever they wanted. Becoming pregnant while not being married was not considered immoral. The child was thought to be a sacred gift for her and her clan, irrespective of the father. All of this was reversed when the British imposed their patriarchal system, which they saw as the natural one.

In the current circumstances, two major issues during pregnancy are paramount due to their

prevalence and severity of their impact: domestic violence and substance abuse, including alcohol. Their prevalence for Native American women is higher than for the general population. This is more likely if the woman lives in poverty, in a reservation, or has antecedents of maltreatment during childhood. This is also true if the pregnancy is unwanted and if she is exposed to multiple psychosocial stressors (Bohn 2003). In many communities the difficult conditions imposed by marginalization and poverty lead to a relatively high prevalence of these issues, alcohol abuse, and domestic violence (Bohn 2002; Malcoe et al. 2004) indicating that probably above half of the women experience such violence. Both have a negative impact on the baby in utero as well as long-term consequences that are well established. The healthcare staff and mental health professionals should explore these issues with any pregnant woman directly and try to remove barriers to the disclosures. This should be approached sensitively in the Native American couple. It will require that the clinician gain the confidence at least of the expecting woman, who may fear that a revelation of this nature may involve child protective services and fear that her child might be removed from her care.

A protective factor is that the family is not conceptualized as "nuclear" which is customary in the more industrialized societies. The concept of family in general is wider, and one might instead speak of "kinship," in a sense of a very extended family (Limb et al. 2008), and in some tribes "family" is all the members of a clan or even tribe (Davis et al. 2014). Our Western concept of "in law" relatives may not exist in some tribes, in which once a person marries, he or she is accepted as a full member of the extended family, like a "blood relative." Those tribe members who are older generally have some responsibility to look after the younger members. This may have a protective effect for those young children whose parents have major difficulties as the family may assume caregiving functions as part of their duty.

Native American infants (Tait 2009) are at higher risk of presenting fetal alcohol syndrome and its partial version, "fetal alcohol effects." These conditions are the leading identifiable cause of intellectual handicap among Native Americans (Committee on Substance Abuse and Committee on Children with Disabilities 2000) and its prevalence is many times higher than in the general population of the United States (Seelau 2012). The clinician evaluating a young child who exhibits delay in development is advised to consider inquiring about the possible exposure to alcohol or other substances, as the most frequent cause of such delays. It is also important to try to prevent this by reminding women that no amount of alcohol consumption in pregnancy is "safe" and detecting women who struggle with major stressors and resort to alcohol to alleviate their anxiety or fears.

Another common issue is obesity (like in many other segments of the population now in many industrialized and developing countries), diabetes, and gestational diabetes, which may have a negative impact in increasing excessively the weight of the baby at birth (Benishek 2005). Also, many metabolic conditions that affect poor communities are particularly frequent among Native American families, such as diabetes, obesity, hypertension, and generally "the metabolic syndrome" and its associated conditions (Wiedman 2012). Many authors conceptualize this as the "pathology of modernity" which traditional cultures experience with great impact when their way of life is altered rapidly due to external circumstances, such as their access to food, work, lesser need of physical activity, and high levels of psychosocial stress. Life in reservations is a particular risk for these circumstances due to the quality of foods available, as well as the other risk factors mentioned.

Delivery Practices

For centuries Native American women who became pregnant have restricted their activities and have taken special care with their diet and behavior to protect the baby. The Cherokees, like most peoples in the world, believed that certain foods affected the fetus negatively. In the Cherokee it was thought that eating raccoon or

pheasant would make the baby sickly, even causing death. In some tribes it was known that consuming speckled trout could cause birthmarks and eating black walnuts might cause the baby to have a big nose. Different tribes still hold various food taboos that vary considerably. As in many other groups, it was believed that "like produces like": making knots might lead to the umbilical cord being knotted, or combing one's hair with a six-toothed comb might lead to the baby being born with six toes, etc. (Waxman 1990).

There were beliefs prescribing and proscribing additional behaviors that were thought beneficial or negative: wearing a neck handkerchief while pregnant might be related to umbilical strangulation, and lingering in doorways might be associated with slow deliveries. Expectant mothers and fathers participated in rituals to ensure a safe delivery such as daily washing of hands and feet. Medicine men were hired to perform rites to make the delivery easier. Sweat baths (inside a sweat lodge or space) might be used to purify the woman and eliminate dangerous influences. Many Native Americans may profess to belong to a Christian religion and, in reality, hold beliefs that are syncretic of the old religion mixed with the new Christian tenets.

The anthropologist James Mooney (2012) observed that among the Cherokee, the birth attendant would try to frighten the child out of the mother's womb. Many indigenous peoples used different remedies. Some Cherokee women used to drink an infusion of wild cherry bark to accelerate the birth process.

Some tribes preferred a solitary birth: the woman would give birth by herself, squatting, in a relatively distant place, while in others the woman was helped by other women and rarely by their male partner. Currently, most births are attended by a midwife or physician, often accompanied by a close female family member, and many women prefer not lying down but being aided by gravity by squatting. The majority of births occur in hospitals, no longer aided by a "medicine man" as it was the custom among the Navajo. In the traditional ritual, the medicine man would perform a "blessing way ritual" (or Hozho) to protect the baby starting in the prenatal stage and during the delivery (Waxman 1990).

Traditionally in many tribes, women would not lie on their back at the moment of delivery but squat. The birth was an affair for women for the most part, and at times a woman would recite "scary narratives" to try to frighten the child to come out of the womb.

The first author witnessed births at a Dine' reservation. The majority of mothers delivered their infants in an Indian Health Service Hospital in Arizona. The most common delivery method was conventional aided by a midwife in the hospital for uncomplicated births and by physicians for complications. However, mothers living in remote areas of the reservation delivered their babies at home aided by a folk midwife or a visiting public health nurse. A thick rope was hung from the ceiling to allow the woman an option to deliver her baby in a way that was culturally acceptable. They were allowed to deliver by knelling and squatting while using the rope to push down on sterilized blankets laid on the floor to catch the baby.

Despite higher-risk factors for having a Caesarean section. Native American women have the lowest rate of this operation compared with other groups in the United States (Mahoney and Malcoe 2005) which perhaps is associated with the policies adopted by the Indian Health Service.

Although many tribes have abandoned religious involvement during the birth process, in the Dine' (Navajo) tradition a "blessing way ceremony" is often held during pregnancy or after the infant is born. Navajo healing ceremonies known as sings, or chants, are designed to restore equilibrium to the Cosmos. Parts of the blessing way ceremony, especially the songs, are included in most Navajo ceremonies. Unlike the other healing rituals, the blessing ways are not intended to cure illness but are used to invoke protections and to avert misfortune for the individual and the community. They are performed to shield the home, to prevent complications of pregnancy, and to enhance the good fortune of the baby and attendees. The ceremonies are highly spiritual, sacred, and attended by family, clan, and close tribal members.

The traditional healing practices and remedies used in Native American tribes have this underlying philosophy of restoring an equilibrium to the cosmos, which has been disrupted (the Hogan is the term used to describe the equilibrium of the cosmos) (Cruz Begay 2004). Such a blessing prepares the infant to make him less vulnerable to witchcraft. The presiding medicine man (hataahi) or woman has to be trained sometimes for years before being able to perform the ceremonies, and they are performed nowadays for a fee that can be high. Often pollen is used during the ceremony, with a feather covered in pollen pointed downward, the pollen symbolizing life and its creation. Like in many other traditional cultures, it is believed that the life of the baby begins with the first breath.

Similar ceremonies may last several days. If a family is not able to pay, they can request from their clan to help finance it. A birth is often announced widely all over the reservation in English and in Navajo over the Navajo radio.

The traditional ceremonies have a direct effect on the participants. In order to understand the calming effect that such blessing chants or prayers can have on the delivering woman and her family, it is necessary to highlight the belief in the power of words and even of thoughts among many Native American tribes. As in other traditional societies, thoughts can cure (and its opposite) and also words, if pronounced in certain conditions. Several observers have underlined how calm many Native women seem to be despite scarce knowledge of the process of childbirth. During the songs and chants, the believers feel that those are the actual words that the Deities pronounced during all important life transitions, such as the creation of the world, those are reenactments. This is also related to the power of storytelling, in which the repetition of old myths have a reassuring effect.

Just as words are important, so are dreams and nightmares. Both phenomena can be perceived as having a real effect in this world and also the state of ancestors and their spirits. Experiences like certain dreams may communicate important things about the state of mind of the person (Tedlock 2004), conflicts, dangers, or blessings, and are often taken very seriously.

Parent–Child Interactions

Navajos and other tribes: Zunis, Hopis,etc; in the southwest of the United States promote the development of the senses for balance in the infant by swaddling their infants in cradleboards as they carry them on their backs. Lakota and Pueblo mothers in New Mexico and Navajo mothers in Arizona, when asked about the advantages of the cradleboard, often explain that besides the ease of transporting the baby on their backs, it makes babies straight and allows them to have a proud posture as adults. Since ancient times, their migratory history favored a nomadic existence and so they carried infants close to the mother's body. Cradleboards are used still in various tribes, like the Zuni, Paiutes, Hopis, Apaches, and others, including the Dine'. Mothers often report that infants are kept soothed and cry less while alert.

A "relative" of cradle boarding is swaddling, which is still practiced, which also occurs in many other traditional cultures in South America, Turkey, China, and many other countries (Gerard et al. 2002). It has been speculated that the practice might be associated with greater prevalence of dysplasia of the hip in infants, but there is no definite evidence of such a maleffect (Manaseki-Holland et al. 2010) as the cause of the condition seems multifactorial rather than related to the carrying method (Holroyd and Wedge 2009). On the other hand, swaddling is associated with less crying in babies who tend to cry excessively and helps calm babies who are exposed to alcohol and drugs in utero. In premature babies swaddling can help their neuromuscular development and generally improve sleep during the periods of swaddling (Van Sleuwen et al. 2007). Old fears that swaddling might impede the motor development of the infant seem unjustified.

Early Childhood

Among the Dine', parents try, from early on, to train the sense of direction and help them memorize the four cardinal directions of their land, which they believe was given to them by their deities. They believe that the limits of their land lays between four ancestral mountains, symbolized by a swastika-like cross to indicate their land and its limits.

Freedman published data on Navajo Indian neonates (Freedman 1974), showing that on the Cambridge Neonatal Scales, Navajo newborns were significantly quieter and less irritable than Caucasian newborns. Freedman later went so far as to suggest that Navajo Indians have used the cradleboard because their infants were genetically endowed with the non-irritability which made it possible to use the cradleboard in the first place.

Infant Feeding

Even though breastfeeding is widely considered by Native American women as desirable, the colostrum (or first milk) may be considered detrimental to the baby, and the clinician should be sensitive to this belief or understand at least why a woman might not think it is a good idea to immediately breastfeed the baby.

There is little scientific information about the rate, duration, and preference for breastfeeding over infant formula during the first year of life. However, a problem which merits special mention is infant and preschool obesity among Native Americans. Among all the ethnic groups in the United States, Native American young children have the highest rate of obesity (Horodynski et al. 2012). The obesity seems to start before the age of 2 years (Anderson et al. 2009; Lindsay et al. 2002). This early onset will predispose later on in life to type II diabetes, hypertension, cardiovascular disease, and strokes (Story et al. 2003). Traditional Dine women nurse their infants for as long as three years.

Concept of the Young Child

In many tribes, the child is not seen as a "property" of the parents as it is common in many Western cultures, but as a "gift" from Nature, and the child is thought to be unique from the start, with individual talents and problems. The child-rearing strategies could be called "child centered" up to a certain age, i.e., the child is not expected to obey the parents blindly or get "consequences" for noncompliance. There is an emphasis on respecting the child and his or her uniqueness. This issue is important because seen from the framework of another culture, it may appear as if the parents are "too permissive" or do not provide enough structure or consequences to their children, and the family may be perceived as too laissez-faire or even chaotic.

Older children are taught to look after the younger siblings and to assist the parents. Children are socialized to consider the needs of members of the community and not only their individual needs. There is less emphasis on achieving material possessions and dominance of nature (Limb et al. 2008).

Many clinicians working with Native American mothers and fathers have the impression that the child is given a lot of "autonomy" or respect for his or her individuality since the child is very small. The concept "*nita*" (it is up to you) is often invoked by parents, shocking Western observers who are used to a more authoritative approach of parents in Westernized cultures. Traditional Native American groups were largely organized on the principle of mutual cooperation and there was little emphasis on coercion or the principle of noninterference. Recommendations from a therapist that involve punishments, restriction of privileges, ignoring the child, or chastising might appear unacceptable or excessive from the point of view of the Native American parent. Sharing one's possessions with others is traditionally more important than accumulating wealth, which may be puzzling for the Westernized observer.

The mother–infant bond is the most important relationship (not the husband–wife relationship).

Groups of sisters may live together with their children and raise them together in a co-parenting arrangement, for instance, among the Dine'. In this culture, which was traditionally a matriarchy, having girls is considered a greater blessing than having boys, contrary to many other cultural groups.

The Westernized distinction between first degree and other relatives is blurred, i.e., "family" includes cousins, aunts and uncles, and other relatives who are "part of the family" and to whom the child will feel connected and owe allegiance. The child should be protected and taken care of by them. Also, older children are expected to take care of younger children and have responsibilities toward them, as it used to be in Western societies where there were large groups of siblings.

The child is thought to be a unique being, sometimes the personality features are assumed to be determined by a specific animal spirit which dictates the predispositions of the young child (e.g., the spirit of an eagle, a bear, a rabbit), and this leads to emotional or behavioral assumptions that are experienced epigenetically as inherent tendencies.

Also, the communicational style between family members, and with other people outside the family, tends to be indirect and based on implied feelings and on actions, rather than on verbalizations or communicating things verbally, such as feelings or perceptions. The mother may never tell her child that she loves him or her, but she manifests her love through actions and implied emotions. The tendency to say things openly and directly may seem rude and embarrassing to the Native American person. Similarly, expecting a person to "express her needs" openly and frankly runs against the notion of implied "guessing" of what the person would like to happen.

Eye Contact and Verbal Interaction

Traditionally, older children were taught to "show respect" and submission towards their elder by averting direct eye contact (Rains et al. 2010). Also, getting the child's reaction to a request or a rule is not expected, but family relationships dictate that the child carry out a request without giving a response verbally, just carrying out the request. If there was any admonition or punishment, it was expected to be endured quietly. Bragging and boasting are considered negative, and the person should rather conceal a good fortune or minimize it, not exhibit it, for instance, about the beauty, accomplishment, or prowess of a young child.

The Long-Term Effects of Previous Policies of Oppression, Obliteration, and Attempts at Assimilation of Children

There is much historical evidence, not only from the United States, but from Canada, Australia, and other countries that previous practices often described as cultural annihilation had negative effects for parents and children. Many native children were placed in boarding schools or even foster homes in order to assimilate them into the "white" or Anglo world. An important question is what might be the long-term effects of those previous practices in the parent–child interactions and emotions of children. Many current parents experienced those early separations as traumatic when they had been forbidden to speak in their native language, and were forced to "abandon old practices."

For a period of time of several decades (1890–1920) in the United States, there was a policy of removal of children from Native American parents (as it happened in Australia and in Canada) in order to promote their "integration" or assimilation into the melting pot of the American society or to embrace the broad Euro-American culture and values (Berlin 1987).

What was the effect of this policy on families? What happened to the children and the role of the mother and father? Many scholars conclude that this practice had the aim of destroying Native American cultures. One of the effects was the disruption of the family relationships as they would have normally occurred. Many children

experienced homesickness and an "alien" discipline style and were exposed to rules prevalent in those boarding schools. How did this impact them in their transition to parenthood and in their infant care practices and parenting beliefs? Boys were forced to have their long hair cut, and they were given military style clothing. Also, they were forbidden to speak their native languages, and traditional names were replaced by new European-American names. Many children tried to run away from these places or from foster homes.

To give an example of the long-term effects of the boarding school system, two adult men professionals described to the first author in 2006 their lost childhood with a great sorrow. They had attempted to escape from the restrictive and abusive Indian boarding schools to try to return to the ancestral home of their grandmother, only to be caught by authorities and returned to the boarding school. They said that only years later, after having returned to the space between the four mountains that mark the limits of the Navajo Nation, they could feel protected and safe. These experiences of segregation and loss have an impact on parent–child interactions to this day. We see a high prevalence of family disruption, high risk for neglect and maltreatment, and parental substance abuse.

In the reservations and in the inner cities, the marginalization of Native Americans is associated with considerable poverty, less access to education and health services, and multiple associated stressors. One of the consequences of all this is that many Native American children are being raised by grandparents, instead of their biological parents (Fuller-Thompson and Minkler 2005).

The Embodiment of Experiences in a Culture of Survival and High Level of Stress

The concept of embodiment contributes to the understanding of how culture and the need for adaptation influences physical and mental health, the sense of self of the person belonging to a certain group (Cohen and Leung 2009).

The concept embodiment (Csordas 1994; Boddy 2011) informs observations of how bodily rituals and expressions reveal the beliefs and practices of people of a given culture. With colonization, the colonized people are often forced to change their dress, their way of eating, sleeping, their sexual behavior, as well as the care of their babies and family relationships, in addition to their language and beliefs. Their traditional rituals have to be abandoned or minimized and substituted for the "civilized" ones (Boddy 2011; Maass 2009). Embodiment also determines our sensations, interactional rituals, sense of self, face to face behaviors, unconscious facial expression of emotions, and unconscious body reactivity in interactions, among many other behaviors. Such embodiment is out of awareness and is routed through perceptual motor systems. It is also part of the early development, where the "codes" of interaction are recorded for the rest of the life of the person.

In the traditional belief systems of most Native American communities, there was an emphasis on cycles, processes, and patterns in nature and the environment. Such processes are still considered sacred: animal flesh, plants or some medicinal herbs for instance, could not be consumed without a prayer. Among the Navajo the term "hataalii" means asking for forgiveness when a part of the cosmos is used for human needs. The remains of encroachment of the culture, displacement, e.g. the "trails of tears," and "the long march of the Dine" and further segregation are experienced in the Native American reservations today with suspiciousness of strangers, mistrust of foreigners, and even aversion to "mixing" with other ethnic groups. Those may be perceived as a further threat to the survival of these minorities. The unease among strangers, the lack of trust, and the cautiousness are a part of such embodiment, which in the clinical setting have to be taken into account.

Traditional Healing

When faced with an illness, the first step may be to consult a native diagnostician (e.g., a "star gazer" and someone who looks through

“crystals”). The diagnostician may refer the patient to a medicine man.

When a Native American family is referred for mental health intervention, it is necessary to take into account a number of cultural codes and practices, as otherwise the treatment may be at odds with the family’s expectations. When the treatment alliance between the patient, the treater, or the treatment team fails, the recommendations may not be accepted by the family, who may just not return, rather than address directly their frustration. For the Western clinician the stance of the parents of a child with emotional or behavioral difficulties may be difficult to understand. In most Native tribes, self-revelation and discussion of one’s internal states are discouraged, being reserved for family members, or just to be kept to oneself (Earle 1998).

Emic approaches to medical treatment consist of a profound, intimate, and empathic knowledge of the ways of understanding disease from the perspective of the patient. On the other hand, etic approaches are the conventional medical strategies, based on descriptive symptoms and signs disregarding the state of mind of the patient. There have been only a few attempts to bridge the gap between these two approaches, the modern medical one and traditional cultural mental health.

A useful concept in working with a minority like Native Americans is the clinician’s “mindset.” Mindsets are lenses or frames of mind that orient an individual to a particular set of associations and expectations. Mindsets, like beliefs, guide attention and motivation in ways that shape physiology and behavior. They are used to make decisions and allow individuals to make decisions quickly and efficiently to solve problems. Sometimes grounded in facts and sometimes not, mindsets are biased or simplified versions of reality; some mindsets might be Indians are “illiterate” or “American Indians are less intelligent” than other people or “they don’t think abstractly.”

As in many non-Westernized clients and patients, for Native Americans the “feeling” one has with a clinician, or the interpersonal experience, the mood, or the nature of the interaction may be much more important than the “scientific” content of the clinician’s interventions, formulations, or recommendations. If there is not a comfortable feeling, the treatment may not be helpful.

Some elements that may be important in interacting with these families may be “taking time” to understand, and to be patient with the communicational style, which may be indirect and not “to the point.” The therapist might also suggest primarily interventions that are acceptable within the cultural framework.

Like that of the client, the clinician’s mindset is also shaped and influenced by factors such as culture, historical multigenerational trauma, religion, social media, social networks, family interactions, etc.

A pregnant woman who develops some complication with the condition, be it physical or a state of depression or anxiety, may be taken to a “regular physician,” who may attempt to prescribe a medication, an antidepressant, for instance. The expecting woman and her family may find this unacceptable although they do not say that to their doctor, so as not to damage the relationship in the future. However, the expecting woman may then decide to consult a medicine man or a traditional healer. The traditional clinician then may diagnose, through crystals or stargazing, that the woman has a condition due to some contact, for instance, with a corpse. This is a taboo in many Native American people, who dread corpses. This contact may be indirect, for instance, due to the patient’s father contact with a dead body. The family may then accept the prescription of a “curing ceremony.” This may result in an improvement in the condition, in part due to the family’s belief in the value of those traditional approaches.

Many Native Americans have their own medical strategies based on spiritual rituals. The Native American client may need to resolve emotional or interactional problems, and therapists or medical practitioners in turn would need to develop an emic approach to understand indigenous community values and approaches designed to develop empathy, i.e., both sides must change their mindsets. It is important to consider issues of life and death and the rituals developed in their ancestral cultures.

Our Western analytic distinction between mind and body may not apply in the Native American individual's mind, be it a child or an expecting woman. The meaning of being healthy or feeling sick is understood as a complex set of mental and behavioral processes involving the sensory systems, muscles and movements, and bodily organs that produce visceral responses as a unit of emotional experience in a unique expressive modality (embodiment). Ecological balance is equated with spiritual-emotional harmony, health, and general well-being. Illness or health expresses a unity and appreciation of the environment and nature that surrounds them.

In the Western view disease is experienced as an enemy of life and well-being. By contrasts in the traditional Native view, disease is a great teacher. Among Native Americans disease is never of the individual alone; rather it involves the family, the community, and their entire world. The breakdown of this network of spirit, body, and community is at the root of "illness."

There are also important cultural differences regarding the meanings of symptoms and the Native understandings of disease. The difference in beliefs often preclude these Native communities from using modern services. Their own traditions include forms of medicine with tools, both ritual and herbalic, that address their needs for cures. This conflicting view of health, disease, and the meanings of life and death contributes to the schism that separates them from well-intended efforts to help their precarious health situation.

Cultural Competency

Today, "Cultural competency" of health practitioners is widely regarded as an essential part of medicine, related health professions, and increasingly also of medical research, particularly given the rising number of ethnic minorities. There is increasing concern in health professions about the ways in which cultural misunderstandings may contribute to health disparities and poor health outcomes. Training in understanding of culture and cultural competence in clinical settings increases practitioner awareness and sensitivity.

Many faculty and practitioners have found that teaching and learning complex concepts of culture and translating them into practice is challenging. Early cultural competency models have been rightly criticized by anthropologists and others as leading to stereotyping rather than informing culturally appropriate care. Those models have focused largely on teaching about the health beliefs, customs, and practices of ethnic and racial groups, which are seen as esoteric and appeal to distant observers uninvolved in universal human emotions.

While this form of teaching culture appears interesting and appropriate for travelers and tourists, it also contributes to a superficial analysis of culture and ethnicity by assuming that different cultural groups are homogeneous entities rather than recognizing the diversity and at the same time uniqueness and communality of experience, knowledge, and practice of individual patients who belong to a different ethnic or cultural group. Medical anthropologists and others in related disciplines have long focused on the nuances and complexities of culture and have suggested new ideas such as the concept of "cultural humility" to educate the student and the mental health practitioner and recommend the use of ethnographic methods in clinical encounters (Kleinman and Benson 2006).

The communication style prevalent in many Native American adults is less direct and "loud" than in the mainstream population in the United States. Problems and stressors may not be communicated as directly as the clinician might expect, particularly when it comes to difficult family interactions or traumatic experiences. Also, body language is an important element in communicating mood, reserve, reticence, or a disposition to discuss something. The cultural patterns of body language vary, but the clinician should be aware that this is a "cultural code" that is used among family members, such as facial

expression, eye movements, body posture, etc. A woman or man may need more time to discuss delicate topics, which are not introduced directly, but only through a circuitous set of sentences and maybe alluding to the problem, rather than stating it directly. As in other cultures, the clinician should be aware of the importance of silence, which a person may need to reflect and to feel. For instance, with the experience of perinatal loss, the woman or couple may prefer just "sitting with them," silently, sharing in their grief and sadness, rather than hearing words of consolation or optimism. In some groups, silence is also a period to listen to the guidance of the "great spirit" which needs to be respected. Indeed, a clinician may perceive the quietness or silence of a client as resistance, when it may reflect the cultural value of timing the expression of oneself and the need to just sit together, accompanying the other as a culturally meaningful way of "being with the other to make each other feel better."

In answering a question, a person might instead of giving a direct answer start telling a story (Tom-Orme 2000) that is related to the causation, the meaning, or the different factors related to an illness or affliction. The clinician is well advised to listen to the story carefully and allow it to develop, rather than expect a concrete and quick explanation of the problem at hand. Since childhood children are told multiple stories in traditional families. Traditionally, the storytelling has a function of conveying values, illustrating the consequences of a transgression, similar to the one the child has committed. Also, the stories convey principles and qualities that are considered important in that tribe (Kroeber 2008) and they are selected accordingly.

To understand illness and health in medicine, psychiatry, psychotherapy, and mental health in general is to allow oneself to address the parallel issues of the individual in relationship to the collective. Healing in any culture can only be in the context of the relationship of the healer to the individual and to the individual's experience. "The Native concept of Healing the American Indian Soul Wound" typically refers to acknowledgment of the existence of the historical trauma that has been transmitted unconsciously and multigenerationally throughout history from generation to generation and from parent to his or her child.

The Importance of Cultural Sensitivity in Treatment: Respect

A common identity in most Indian cultures in the United States is their personification of the value of noninterference. European-derived cultures place primary emphasis on the individual and the material world. By contrast, cultures native to North America revolve around a network of family, social, and spiritual associations. The family, the tribe, and the clan are the agents that teach and place emphasis on traditional values in which the original stories give the sense of historical continuity and identity to indigenous identities. Humility in the face of the complex situation is a useful strategy to start doing justice to "the other" whom we may not know, but gives us the opportunity to enter his or her world and to help.

Fig. 8.1 Totem. (Original artwork by Ana-Marcela Maldonado-Morales)

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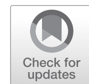

9 Working with Asian Families, Infants, and Young Children

Kenichiro Okano

Some Commonalities to Asian Cultures

The clinician practicing in an industrialized country is likely to come across immigrant clients and families from China, Hong Kong, Vietnam, the Philippines, and Japan, among others. Obviously "Asian" does not mean uniformity in parenting beliefs, practices, goals parents want for their children, nor how they deal with various aspects of the care of the pregnant woman or of infants. In this chapter, after addressing some commonalities in some Asian countries, the author focuses on issues related to the general notion of "living for others." We focus on the other side of the coin of "individualism" and address the issues associated with intense interdependence and the individual belonging to a wide social and cultural network from which it may be difficult to differentiate oneself. Much of the chapter refers to the particulars of Japanese culture, but many of the principles resonate with other Asian cultures.

Some Common Issues in Asian Parents and Their Young Children

Like in other regions of the world, there are wide variations in family relationships and beliefs even within each country in Asia, between urban and rural families or "modern" families versus "traditional" ones depending on the multiple ethnicities. Many of the issues we discuss with traditional families may be quite different in the more urbanized or Westernized families, even in terms of the family structure, composition, and roles. In those situations, there may be a blend of "old and new values" in different combinations which only a detailed knowledge of each family would allow to understand.

In most traditional societies in Asia, the role of women is strongly identified with becoming a mother. Being pregnant is an important component of that. If a married woman is unable to conceive, there may be a social stigma and, in some cases, actually rejection of the woman as somehow "guilty" of being unable to produce children. She may think of that difficulty as some form of punishment or a sign that there is something wrong with her. As a corollary, women may go to great lengths to become pregnant and experience intense emotional difficulties if they are unable to. In the case of repeated miscarriages, these may also be considered as a further stigma on the woman or couple, and she or they might see themselves as inadequate or cursed.

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In the traditional family relationships, the care of young children is mostly left to the mother and her female relations, with the father minimally involved particularly with babies. The father is generally much less involved in the day to day care of the young child, particularly when it comes to emotional involvement and support (Holloway 2010). During the twentieth century with increasing industrialization, men were socialized to be devoted to the need to work, and often they "served" the same employer for decades. This is changing but, still, many men are "chained" to long work hours and trapped in a highly competitive work environment. Perseverance and patience were important values in such a work ethic.

Regarding parental beliefs about children, an important contrast between most traditional Asian values and European Calvinist beliefs is the latter's conception of the young child as innately evil or included to do bad things. In that Christian belief system, children are thought to have a need of firm discipline from the start to curve their negative tendencies, which always have to be kept in check (Jolivet 2005). In contrast, the traditional Confucian ideology that permeated many Asian countries emphasized the innate goodness of the child, which has to be just nurtured (Chao and Tseng 2002) particularly when the child is very young.

A related idea is the Japanese word *amaé*, which encapsulates the ideal of benign acceptance of the child's dependence on his or her mother (Behrens 2004). The intimate connection between the mother and infant can be described as the mother perceiving the baby as an extension of her own self (Bornstein and Cote 2001). Child-rearing based on those principles (including Buddhist ideas in many areas of Asia) emphasizes and reinforces virtues like perseverance, patience, kindness, and interdependence. This is different from Westernized cultures where parents reinforce originality, individuality, self-assertion, and exploration (Bornstein 1989).

In some countries of Asia, like China, Korea, and Japan, families tend to have less children (or only one or two as in China), while in others like Malaysia, the Philippines, and India typically parents tend to have more children. This difference probably influences how one views the infant and young child and how the child is raised. If one only has "one child" he or she might become the main focus, and only opportunity, for the mother to raise that precious child. Many mothers experience intense anxiety about child-rearing, and increasingly also do fathers (Sumida and Fujii 1998). Modern parents may rely less on traditional practices and seek "the best methods" to produce a well-balanced, happy, and successful child.

Care of the Infant

Although there are variations and a trend toward Westernization among urban and more educated segments, the traditional practices are still valued in the majority of the population in most Asian countries. There is a strong emphasis on continued physical contact between the mother and the baby, and babies co-sleep with their parents on the bed, on a mattress, a hammock, or a futon on the floor. This is related to the belief in the importance of continued direct monitoring of the baby, tending to the needs, not letting the baby cry for long, or soothing the baby quickly. Carrying the infant is encouraged, particularly by mothers. In many rural areas the mother will carry the baby most of the time when she is outside, in a shawl or other piece of cloth around her body. In large segments of India the tradition was that the mother in law of the new mother would guide her and help her to take care of the baby (Patel et al. 2010). Among the more affluent families, the mother may employ a nanny to take care of the infant most of the time.

The Appearance of the Infant

In India, Bangladesh, Pakistan, and other countries, the color of the baby's skin is the object of much interest, and parents would prefer a "lighter skin color" or as pale as possible as more desirable. If the baby is too dark, this may be a sign of diminished beauty and desirability or of a lower social status in the future. Parents in most Asian countries very much desire to have at least one

male infant. This is related to the traditional role that men had in society, as having a duty to take care of their parents as the boy becomes an adult. In India even though dowries are not officially sanctioned, traditional families still have to save money to provide a dowry when the time comes to marry off a daughter. If one were to have several daughters, this would be a major problem financially. Also, there is often a preferential treatment for boys. A son may be fed with priority and treated with more leniency than a girl (Isaac et al. 2014).

To the more Westernized observer, the practices of infant care in many Asian families seem to "overindulge" the infant and to prolong dependency on the adult caregivers for a much longer time that is customary in modern Westernized societies. Mothers may spoon-feed the child up to age three or four, in order to encourage him or her to eat enough and a variety of foods. Parents may carry things for the child in the preschool age, such as their lunch box and backpack, and hang the child's coat when he or she arrives at the preschool setting. When the young child plays, the parent is expected to pick up the toys, not the child. Parents sleep with their children for a number of years, much longer than is typical in the West. These practices are important to promote parent–child closeness, allow dependency on others, and promote social bonds. The mother is less likely to issue "direct commands" to the young child and if he or she does not do what is expected, the mother is unlikely to punish the child. The preschool-aged boy or girl might instead be told that mother or father would be disappointed, or a grandparent might be sad if they were to know what happened, but direct coercion or punishment would rarely be used.

As one evaluates a family, the clinician should keep in mind that many marriages in Asian countries are "arranged." The parents or other older relatives (like grandparents) have a hand in selecting one's partner and families enter into a contract. The relationship between the spouses is not necessarily intimate in terms of loving or confiding in one another, emotional support, and satisfaction. Most of the emotional support for the members of the couple is obtained from members of the family of each spouse or close friends. There is still a strong sense of obedience and respect for elders and of fulfilling one's family obligations, such as having children, being responsible, and caring for them.

The Role of the Father

In general, fathers are less involved in the care and emotional life of their children than mothers in many Asian families, particularly the traditional ones (Shwalb et al. 2004). In Japan, China, and Korea, the father is expected to enforce rules and expectations, along, broadly speaking, Confucian principles and also to instill filial piety, by which the children as they grow older might eventually take care of their parents. This is changing with modernization and globalization particularly in urban areas. Part of the diminished involvement of fathers in comparison to mothers is related to long hours of work and the cultural expectations of men to be available to deal with company business. This is often the case in Japan: men may socialize with co-workers after the work hours and come home late, not spending much time with the children. The bulk of the everyday parenting and nurturing is left to the mother.

The Other Side of *Amaé*

In principle, *amaé* is a Japanese term which refers to the close bond between a caregiver and a child, often the mother and her baby. The baby "basks in the mother's love" and she is utterly devoted to the baby. Her emotional reward is to be a good mother and to have a deep lifelong emotional connection with her child, who in turn loves her. They, so to speak, "read each other's minds" (Okonogi 1992). This is considered a cultural ideal that the baby experiences this "specialness" from at least one caregiver in order to be protected for life with a feeling of being loved and accepted unconditionally.

One of the possible effects is that the nature of interpersonal relationships in Japan has been described as shame-prone (Benedict 1946) or amaé-based (Doi 1972). Okano (1994) has

described interpersonal sensitiveness and passivity as a common theme in the interactions among Japanese families, but with different terms and manifestations it occurs in many traditional cultures in Asia and many other traditional groups. One aspect of *amaé* that often is not considered is the negative aspect of this intimate reciprocal relationship. Okonogi (1983, 1992) described this relational style as "others-oriented," i.e., the individual is very keen and sensitive to what others think and especially what they expect. This way of interacting then applies to many other relationships, especially intimate ones later on in life. Watanabe (1992) has emphasized the modern uncertainty in Japanese society of "how much *amaé*" is good for their child, a question which at times inhibits the intuitive aspect of parenting.

As in many interdependent cultures, many Japanese use their "social skin" to perceive each other's expectations of them (Tatara 2005) in order to function harmoniously in society. This might create a very stressful relationship in some cases, where incessant mutual mind reading is required to maintain one's social life. Many Japanese people have an eye-opening experience when they go abroad and are exposed to different cultures, where they find that they no longer need to read what others expect of them at all times, as others do not have that type of relational pattern. Mutual mind reading is, in fact, one of the important factors, not only in *amaé*-based relationships but also in early mother–child dyads across cultures. The notion of "passive object love" proposed by Ferenczi and Balint (Ferenczi 1931, 1949; Elder et al. 2003) clearly indicates this issue. However, although mutual mind reading could continue to exist after childhood, in a healthy manner, depending on relationships and social context, it can sometimes get out of control.

If a mother's *amaé* wish becomes too strong, the mother–child relationship develops into a unidirectional and demanding relationship where no true *amaé*-based relationship is achieved. In the clinical setting in Japan, one is often especially faced with some mother–daughter relationships, where excessive mutual mind reading could lead to a type of master–slave relationship. In the worst cases, the mother might end up reading what is not there in the child's mind. For instance, a message "I know you are anxious to be alone" might be perceived by the child like a fact, even if the child is not really anxious. Thus, excessive or inaccurate (based on the mother's anxieties) mind reading might end up being thought implanting, creating a highly traumatic and "dissociogenic" (Okano 1997) relationship, i.e., inducing a tendency to experience dissociative experiences. This means to experience part of oneself as separated or disconnected from the main self.

Previously, Okano described Japanese relationships from the viewpoint of their interpersonal sensitiveness and passivity (Okano 1994, 2017). Additionally, many Japanese people experience a lot of stress in their relationships with others, resulting in various types of psychopathological tendencies. There are both positive and negative aspects of an *amaé*-based mentality. Here we describe also a number of experiences of transculturation to highlight the contrast between a Western culture and the traditional Japanese interactions.

A mental health clinician returned to Japan 15 years ago after an extended stay in the United States; several things were striking in the new workplace. When he asked a human resources official if he could use a certain proportion of his annual leave to go to the dentist, the official looked puzzled and said that she had never heard of this type of request. After further inquiry, she told him that employees did not care how many annual leave days they had, as nobody used them all anyway. There was an unwritten rule that employees did not take time off, except for special circumstances, when the supervisor acknowledged such a necessity. The newcomer gradually noticed an underlying assumption that working selflessly for one's corporation or organization was considered a virtue. In the evening, the later the employees stayed in the workplace, the better the employee appeared to not only their supervisors but also their colleagues. These issues have now evolved to a degree. The ambiance in Japanese corporations has changed somewhat, as many corporations are urging their workers to leave work on time. However, the tendency to prioritize the group that they belong to over themselves still persists in many workers' minds.

This can also be seen in the relation between parents and the schools. In many preschools and elementary schools, parents are asked to "volunteer" for various activities led by the parent–teacher association (PTA). Many mothers feel that they do not have an option to turn down the PTA's solicitation for their cooperation. The observer would be impressed by the group-oriented and self-sacrificing mentality, which is in stark contrast to the individual-oriented American society. What seems certain was that many or most Japanese value how they appear to others rather than how they think about themselves.

As noted, Okonogi (1983) proposed that the Japanese are typically "others-oriented." Instead of behaving autonomously according to their own value system, they tend to be driven by a "heteronomous" sense of shame. Okonogi stressed that in Japan, people strive to imagine what others expect of them and try to comply with these expectations as much as possible.

The "Skin" as the Organ to Read Others' Minds

There is an expression in Japanese without an equivalent in European languages: "*kūki wo yomu* (to read the air)," which figuratively means "to perceive unwritten messages" or "take a hint" in a given interpersonal situation. "To read the air" is to detect nonverbal nuances or assumptions in group or interpersonal situations and respond appropriately to them. For example, when a group of people have a discussion to reach a decision, members try to see the most senior or influential person's viewpoint. Openly opposing that person's opinion could humiliate him or her and would lead to not receiving other members' support. In addition, the senior person also tries to understand members' views, so that his or her view is not too discrepant from theirs and will receive unanimous approval. The whole group tries to make this process go smoothly so that no one loses face. Most of these processes occur through nonverbal "reading of the air," and those who are not able to do so cannot be a part of the process and tend to be excluded from the group. While similar nonverbal communication may exist in Western societies, it is the predominant way of communicating in Japanese society and to a higher or lesser degree in many Asian communities.

Yet another example is when after having dinner in a restaurant, members of the dining party should "read the air" as to who pays for the entire group. If everyone is on an equal footing, such as classmates or sports teammates dining together, they simply split the bill or pay for their own meals. However, if there is some seniority among members, things can become complicated. In Japanese society the most senior person should "be honored" to pay for the rest of the party. If someone else with a good heart does not "read the air" and volunteers to pay for the entire group, this action could be viewed as disrespectful to the senior person. This may also apply to families and their hierarchy regarding age or a position of authority.

In this context, Japanese psychoanalyst Tatara proposed the idea of "skin ego," a relevant notion in our discussion of people's capacity to "read the air." He proposes that in Japanese society, "people need an organ to sensitively perceive social relationships and hierarchies" in order to get along with others. He states that figuratively speaking, the ego of Japanese people is located at the "skin level." He proposes that interpersonal the relationships of the Japanese allude to their ego being structured quite differently compared to Freud's notion of the ego. Tatara proposes that the Japanese ego cannot stand on its own but is protean and influenced by what other people expect. He called this the "amorphous ego" (Tatara 1994). With the sense organ of the "skin ego," a person constantly "reads the air" and speculates what other people expect. We can correlate this concept "skin ego" theory to Winnicott's notion of true self and false self (Winnicott 1965). For the Japanese, the false self is actively reinforced while the true self tends to become unsubstantiated in social interactions. For the false self to function in society, the social skin, which forms the main part of the false self, becomes a crucial perceptive organ with which people read others' minds to understand nonverbally what is expected.

The Experience of Relief When Abroad

Most Japanese are so accustomed to relationships based on mutual mind reading and mind speculating that they are not aware of the stress this can cause in their social lives. However, if they experience different types of interactions in other countries, they often recognize the stress level that they are exposed to in their home country. The clinician often will encounter this when working with patients who speak about their experiences abroad. They are often impressed by the fact that in Western society, they felt relieved of the tension that they usually suffer while in Japan. This can take the form of a symptom relief.

Some patients with social anxiety symptoms report significant improvement in their anxiety levels when they move to another country. The symptoms of a young woman with compulsive handwashing disorder may be dramatically reduced while staying in England for example. A middle-aged woman's wrist cutting seen by the first author reduced by half in terms of seriousness and frequency while she was staying in the United States.

The countries often mentioned were typically English speaking, like the United States (including Hawaii), Canada, England, and Australia. What they said was that when they are there, they did not need to think as much about others around them.

One young man explained that in such a country, "others are not paying much attention to me." Of course, as a foreigner he must have attracted some curious looks from people, especially in less populated areas. However, the looks he attracted were not just out of sympathy or compassion. If he was judged as safe, people stopped watching him and began going about their own business. Nonetheless, some people might be eager to help foreigners who need assistance and they usually assume that if foreigners need help, they will say so or act in a way to express their needs. They do not see any reason to exert their mental energy speculating on a foreigner's unexpressed needs.

In multiethnic or multicultural countries, it is even harder to guess correctly what others feel and think. In such countries, therefore, it is imperative for people to express clearly and verbally what they need from others. While this might make Japanese travelers feel even lonelier and anxious in foreign environments, they often experience a relief as there is not much mutual mind reading involved.

This phenomenon reminds of Takeo Doi's experience depicted in *The Anatomy of Dependence* (1981). When he was invited to stay with an American family soon after he began his life in the United States, he was asked if he was hungry. The host suggested that she had some ice cream to offer. Doi said "no" as he was afraid that he might appear too direct and greedy if he said "yes"; however, the host simply said "OK" and never offered him ice cream again. Doi found the host's attitude dry and dismissive. He wanted the host to read his mind, as a Japanese host would do, and know that he was actually hungry and insist due to politeness, but this never happened. This experience, among others, led Doi to discover the meaning of *amaé*.

While it might be ideal if people understand each other's needs nonverbally, it can be very taxing as well. Let us imagine this situation: a neighbor appears to be suffering from some emotional stress. One might try to understand his pain and what he is expecting one to do for him. If this works well, there is no problem. However, understanding the neighbor's mind might not be a smooth and easy process. It might extend further if one is not sure of reading his mind well enough. The process might go like this: you try to read his mind → you try to see if he expects you to read his mind → you try to see if he really expects that you would read his mind to see if he expects you to read his/her mind. This process might continue ad infinitum. In addition, your neighbor might be doing the same thing, which complicates your attempt to read his mind. If something irregular happens during this process, even if your neighbor never expects his mind to be read or speculated about in the first place, you or your neighbor might feel misunderstood, ignored, or betrayed. That sense of betrayal might not be conveyed to

the other party, further widening the emotional gap between the two.

One may try not to read other people's minds to avoid any misunderstandings, but in Japanese society, such a person might be stigmatized as "a person who cannot read the air" and be treated as an outcast. While living in Japanese society, and to a certain degree in other Asian countries, it is not possible to escape the fact that relationships are based on mutual mind reading.

In a society so steeped in the type of mutual mind reading described earlier, this may be the basis for the so-called gift culture in Japan. Gift giving occurs very frequently when people visit each other. When people give a gift to someone, they say, "This is just a small token, but …" Sometimes, though not frequently, people even add, "If you don't like it, please just discard it." One might want to ask what this person really means. The person might be thinking, "You probably want a gift from me, right? Therefore, I brought you something that is not really a small token. But, you might not like it. In that case, I assume that you might want to get rid of it. So, you should not feel guilty about doing so, as I am already forgiving you." Thus, the gift giver is reading the receiver's mind, even before the latter has received the gift.

Amaé and Mutual Mind Reading

Okano proposes that mutual mind reading is the foundation of *amaé*-based relationships. As is well known, in his book, Doi (1972) stated that *amaé* is a special kind of dependence, for which an equivalent term is not found in Western society. He discussed that a child controls the mother with his or her *amaé* need while keeping a passive stance; the mother also fulfills her own *amaé* needs in a vicarious way. *Amaé* invites love and affection from the other person, as it appeals to the *amaé* need of the other. Doi compared this process to the notion of "passive object love" proposed by Ferenczi (1931) and Balint (1936). In object love, a person loves another person actively and spontaneously. However, "passive object love" connotes a paradoxical act of spontaneously seeking the experience of being loved passively.

As Ferenczi and Balint considered this type of love as the basis of mother-child relationships in Western society, amaé-based relationships may be universal across cultures. Consider the image of a nursing mother and her baby. The baby initially cannot convey his or her needs to the mother very well, and the mother sometimes might not understand what the baby really wants. When the baby cries due to hunger, the mother reads the baby's mind, assumes that the baby is hungry, and nurses him or her. When the baby is full and smiles at the mother, she assumes that the baby wants her to smile back and cuddle him or her. If this type of mind reading on the part of the mother is absent, it would be stressful for the infant and the baby's experience would be barren. Thus, mothers' mind reading of the baby's needs (and perhaps the baby's mind reading of the mother to some extent) exists in a healthy way in early mother–child relationships.

Winnicott described a similar maternal function, where a mother contributes to the baby's experiences of illusion. In his conception, the child "hallucinates" or has *reveries* about the mother's breast when hungry (Winnicott 1945). If her breast is presented when the baby is thinking about it, the baby has an illusion that he created it. In this process, what is crucial is the mother's capacity to understand what is going on in the baby's mind. This idea seems very close to Doi's notion of *amaé*.

The act of mind reading does not have any specific endpoint. It would lead to limitless mind probing. A pathological manifestation of mind reading can be found in some parent-child relationships, especially mother-child relationships: a parent tries to identify a child's needs and responds to them. The child experiences the gratification of *amaé* needs based on the parent's sensitivity and healthy mind reading capacity, ideally exercised, for instance, during "primary maternal preoccupation" (Winnicott 1945). In a majority of mother–daughter relationships, a friendly and affectionate relationship can be created along

with the daughter's physical and emotional maturation. However, in some mother–daughter dyads, the relationship becomes one of domination. The mother, who initially wielded her power as the fulfiller of the daughter's *amaé* needs, later on takes the position of the daughter by demanding that her own *amaé* needs be met and expects that her mind be read and responded to by the daughter.

Of course, the same can occur in mother–son relationships. However, when the mother tries to keep her son within her emotional orbit, many sons evade that attempt without feeling excessively guilty. Although each relationship is indeed unique, many mother–son relationships do not seem to be as susceptible to the pathological level of mutual mind reading that is often seen in many mother–daughter relationships.

Psychopathology of *Amaé* and the Origin of Dissociation

As for the pathological manifestation of *amaé*-related relationships, the discussion of the Japanese terms related to "*Amayakashi*" (similar to the word "pampering" in English) is of special interest. The verb "*amaéru*" (child demonstrating amaé needs) corresponds to the verb "*amaésaseru*" (parents fulfilling child's *amaé* needs). However, there is another verb "*amayakasu*" that means "excessively fulfilling the child's amaé needs," nearly equivalent to the English phrase "to spoil (a child)" (Henshall 1999). Based on Cho (2002), "*amayakashi*," the noun form of the verb "*amayakasu*," is the act of imposing the parent's *amaé* demands onto the child: The child loses his activity and succumbs to the parent's tacit need of *amaé* onto the child. The child then needs to set up a façade to accept the mother's *amayakashi* (spoiling), thus creating and promoting the development of a "false self."

It is necessary to emphasize the difference between an "amaéru-amaésaseru" (spoiler-spoiled) relationship and that of "amaéru-amayakasu." In the latter relationship, the mother entices the child's *amaé* needs and takes advantage of them. The mother typically has never experienced real *amaé* in her childhood and does not know how to fulfill the child's natural *amaé* needs. The child ends up not experiencing the real *amaé* and becomes part of the intergenerational transmission of "faulty *amaé*" (Cho 2002).

Healthy mind reading is the basis for an *amaé*-based relationship; however, in *amayakashi* (spoiling), there is a force exercised by a domineering parent. The mother or father might immediately buy whatever the child wants, depriving him or her of his wish to act spontaneously and to react to frustrations. Thus, he might not be given the opportunity to deal with frustration and anxiety on his own. What is critical is the fact that it is the mother who experiences anxiety first and capitalizes on the child's *amaé* needs to soothe her own anxiety.

A healthy child might perceive the parent's self-centered attitude as disturbing and try to avoid that person. Contrary to what might be expected, it is possible for the child of a spoiling mother to mobilize his own defensive maneuvers to get away with whatever he needs from the parents, but then refuse intrusions from them. However, if the child is also constitutionally anxiety prone and insecure, he or she might respond to the spoiling parent in exactly the expected way: if a mother tells him "you might be anxious and need my help," he might be convinced. Thus, excessive mind reading can become mind indoctrination.

In clinical practice one often sees patients, particularly women, who say that they cannot experience feelings of anger or frustration on their own, due to their stressful relationships with their mothers. There seem to be several different levels to this problem. In less pathological cases, the daughter prioritizes her mother's feelings while keeping her own feelings to herself. The daughter uses her own skin ego to read her mother's mind and deal with it tactfully while keeping her own self intact, without her mother being aware of it. On a more pathological level, the mother urges her daughter to read her mind and

cater to her needs and the daughter obeys her mother while sacrificing her own feelings. Her true feelings might get dissociated and she might not be aware of them.

In the past, Okano hypothesized on the pathogenesis of dissociation (Okano 1993) arguing that dissociation is used when a child is prohibited from expressing his/her needs, either directly or through projection and externalization. In the pathological *amaé* relationship, mind implanting can create a situation in which one's true thoughts and feelings are pushed aside by whatever the mother puts in the child's mind, thus creating a situation conducive to dissociative pathology.

Implications for Mental Health Interventions in the Clinical Setting

As the detailed description of the poles "living for others" and "living for oneself" demonstrates, there is no precise formula to attain happiness in families with strong traditions of extended family involvement. The solution does not seem to be to "cut ties with extended family" as this violates many of the traditional practices in those societies. Also, it may not be useful to defer totally to the pressures and desires of extended family members at the expense of one's own beliefs, desires, or values, when these differ from those of the relative. The challenge is to achieve a balance between being part of an extended network of family ties, also having an acceptable degree of autonomy and self-determination. As a recent study demonstrates, the help of extended family members comes at a price (Sonuga-Barke and Mistry 2000) particularly when a new mother feels criticized and devalued by "elder women" who think they know best how to care for the child and want to impose their beliefs on the young mother. On the other hand, total isolation may also be very costly, as the wisdom and involvement of older family members may be quite valuable and provide necessary relief for the new mother, when a supportive and respectful relationship is possible.

Taijin Kyofusho (Fear of Interpersonal Relationships)

This is a culture-bound syndrome that has been described in Japan in particular (Iwase et al. 2000) but is seen in other Asian countries like Korea, where it is known as *taein-kongpo* (Lee and Oh 1999), and elsewhere. It consists of a form of social anxiety, but instead of the common form seen in the West (the fear of being the object of attention from others, being seen, etc.) in this case the person is afraid of offending others or annoying other people. This is perhaps the pathological form to the "living for others" notion described above. The sufferer, like a new mother or a pregnant woman, may be very afraid of offending others or even of attacking them. Sometimes this is manifested as the fear of having a "bad odor" in one's body (also called *jikoshu-kyofu* or osmophobia) and being thus offensive to other people, even when the smell is imperceptible to others. The fear of embarrassing other people may be based on the perception of an undesirable physical appearance. There may be blushing or sweating when one is in the presence of others. Also, there is a phobia of one's own glance, as possibly causing embarrassment to others or even harming them: *jiko-shisen-kyofu* (Iwata et al. 2011). A related condition is the state in which the adult is confined to his or her room and does not go outside sometimes for months, except to eat, for fear of being seen by others and having to interact (James 2006). This has been described in European, Canadian, and Australian patients (Kim et al. 2008). Even if the clinician does not see the extreme forms of this pathology, it is more prone to manifest in cultures in which individuals are often afraid of doing something embarrassing or offensive to others, which would affect their behavior in a clinical session, if they dared to attend one. It has been suggested that its origins may be in the nature of the mother–infant relationship and the mother allowing "excessive dependency" (Sharpless et al. 2016), as well as a tendency in the mother to embarrass the child, to make him/her feel ashamed, and to highlight the

negative impact on the child's behavior on her emotions. Also, since direct eye contact was traditionally discouraged from children toward parents, this may be related to the fear of offending others with eyesight.

Hikikomori

This condition is mentioned here because it exemplifies one of the anxieties that is necessary to understand in many Asian families, the fear of "losing face" prestige and of confronting other people, i.e., to the people "from outside."

Hikikomori in Japanese means "turning inward" and "being confined" or "housebound" (Guedj-Bourdiau 2011). Those who suffer it can be considered as modern-day "hermits" who can be men or women. It has been described in many other individuals who are not Japanese, in several other Asian countries (Kato et al. 2012).

Some Cultural Codes

By cultural codes we refer to the way people may interact with each other as a matter of course, custom, or tradition. They are generally unconscious and "automatic" and they may be different in people from various different areas and backgrounds. We refer here only to some that may be mistaken by a Western clinician unfamiliar with some of those codes.

Eye Contact

This is a highly valued behavior in the Western world as a sign of frankness and openness or friendliness and trust. This is not so in many Asian countries, in many groups from India, Japan, China, Korea, etc., eye contact is not encouraged with strangers or with people in a "higher" social position, such as a clinician. When one attempts to talk to the person, the deviation of the eyes to one side or downcast eyes, even if subtly, should not be taken automatically as a sign of evasiveness, defensiveness, or sadness, but it may be a sign of respect. The same would apply to children, even to infants, who are not encouraged necessarily to be *en face* with their mother or father and therefore have not learned that behavior as they interact with others.

Smiling

At times the Western clinician may be struck by how a person might smile or even laugh at the "wrong moment," such as when the person talks about something sad or embarrassing. This may represent a social behavior meant to soften the interaction and to not make the other person uncomfortable, for instance, when one reveals something sad. At times a person may just smile in response to a question instead of saying "no" or denying something. This does not mean an assertion of agreement, but it may represent its opposite. In many Asian cultures it is considered rude to express disagreement openly or to say "no" to something such as an invitation to a place or a request to talk about something. The smile may appear "inappropriate" as when the person does not say anything and is really avoiding to say "no" directly. Also, there may be laughter when one refers to one's parents being difficult or to a family problem, it does not necessarily mean that the person actually finds the situation amusing, but it may be a social code to not embarrass or burden the listener. Similarly, a person may agree to come to the next session, but this does not necessarily mean that they intend to do so, but simply that it would be very difficult to directly decline the offer of another session if the person felt uncomfortable or uneasy.

Negative Statements About the Young Child

If the clinician praises a young child as being "beautiful," "cute," or "intelligent," a parent may respond with some unease or anxiety and then say something negative about the child, such as "but he is lazy" or "but she has a large head" or even "but he is stupid." This is meant not to appear to be bragging or being delighted due to

the beauty of one's child, which is considered rude. The rules of etiquette dictate that one should "take off" from the statement made by the other person, by pointing out to something negative. Similarly, a parent would hardly be able to say, "my child is the most beautiful baby in the world," which would be unbearably rude and is meant in the West merely as a manifestation of love. The parent may appear subdued in expressing joy about the baby and this is meant to not offend others with boastful statements about how great one's child is or how happy one is.

Issues in Psychotherapy or Parent–Child Therapy

Each family has a set of assumptions, values, and beliefs that are unique and no generalizations are possible just because of country of origin, religion, ethnicity, etc. An Asian family may be cautious about revealing their beliefs if the clinician does not ask about them or conveys that he or she values their traditional wisdom. The clinician might attempt to allow the family to express openly their theories and beliefs without fear of being prejudged or thought ignorant or superstitious. The etiological theories may include the notion of offending ancestors, for example. In many cultures ancestors or dead family members are treated as though they were still around and very present with the family in some way. In Japan they are venerated (*sosen suhai* can be translated as ancestor worship). If an adult does not honor or properly tend to the ancestors, showing veneration and respect, this is an offense that can bring about negative consequences. The dead can include children one has lost, as in a stillbirth or pregnancy loss. It has been suggested that the process of mourning may be different in that cultural context (Klass 1996). What in the West we consider as "pathological mourning," i.e., not letting go of the dead, in other cultural context, may be a way to "keep in contact," even though the person is no longer in the flesh and moving in front of our eyes.

Another issue is having committed an offense in a previous reincarnation and receiving a punishment now. Also one can be a victim of the negative feelings, desires, or intentions from neighbors or relatives.

These "personal theories" based on traditional beliefs are essential to take into account in terms of developing an intervention strategy that makes sense to the family and guiding what can be done to improve the problem at hand. If the clinician is uncomfortable or uncertain or does not know how to relate to these etiological theories, he or she may act as though there were no cultural differences between him- or herself and the family, i.e., "putting the differences under the rug." Clearly, the clinician should ultimately be able to relate to any family no matter of what background, as there is much in common in the human condition and family relationships, more than differences. However, acting as though one "did not see" differences in beliefs or practices may feel very distant and contrived to the family with which one is dealing.

A family may believe in the importance of resorting to a fortune-teller, a Shinto priest, a Buddhist monk, a traditional healer, etc. The same applies to the use of charms and amulets or any other object that might have protective or cleansing functions. The clinician might coordinate interventions with this traditional healer or religious figure in order to help the family and gain their trust. Only rarely there would be a strong contradiction in terms of interventions.

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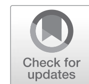

10 Working with Families, Infants, and Young Children from the Middle East

Youssef Hrar and Muhammad Farhan

The mental health professional working in most countries in Europe and North America is bound to encounter children and families who have emigrated from one of the countries in the Middle East. It seems that understanding the point of view and values, ideas, child-rearing strategies, and strategies that families hold, as well as their view of some problems, might help when one works with families with that background. We emphasize here the "traditional" beliefs and practices, which might not be applicable to populations that are more modern and cosmopolitan, as in some of the United Arab Emirates (Green and Smith 2007) and every other country in the Middle East, where there are very "Westernized" families and others in which there is vast poverty and traditional values and practices dominate.

The purpose of this chapter is merely to address some of the common issues that clinicians working in a "Westernized background" can confront in mental health work with young children and the perinatal stage with families that come from the Middle East.

An important aspect of this chapter is to try to address some of the common stereotypes and misconceptions that are likely to be part of the frame of mind of a Western mental health clinician and certainly of the public at large. In the past 10 years, there has been an increased "fear" of Islamic influences, and there is in some places almost a climate of paranoia and anti-Islam sentiment, both in Europe and the United States.

The most widely practiced religion in the Middle East is Islam, which is the second largest religion in the world (about 23% of the population), after all the Catholic/Christian believers. Having some understanding of its main principles and how they impact everyday life, family relationships and early childhood would be useful to the clinician working with a person from those areas. For Muslims the religious precepts stem from the *Qur'an*, the sacred book thought to be inspired directly by God (like the Bible), and the *Hadith*, which includes the sayings of the prophet Mohammed.

Rapid Social Change in the Middle East

Due to a multitude of factors, including economic ones, such as the West's need for oil, political influence zones, history of colonial-

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ization in many of these countries, and "globalization," the Middle East is an area of rapid social change. The cultural patterns and practices that may have been stable for centuries have given room to a "patchwork" of cultures, practices, and values, influenced by forces of "modernization" and also voices of "traditionalism," which oppose such changes. It can be said, however, that in general after a process of "Westernization" in countries like Iran, Egypt, and others, there was a resurgence of the more traditional values, including the return to the use of head covers for women, increased restrictions on women in general, and the return of Islamic religious groups to a position of great influence.

In any case, traditionally most people in the Middle East rely more on their extended family to meet their needs than on governments or public assistance, which creates the need for faithfulness to the family and maintaining a strong sense of coherence in that network (Dwairy 2006). These values will be passed on to a higher or lesser degree to next generation. Children are exposed to a variety of relatives, aunts, uncles, cousins, etc., which provide support and also intervene in all family affairs. A very important value for families is their honor and maintaining its image and prestige. This tends to control the behavior of all family members who experience strong pressures to comply and maintain the honor and image of the whole family.

A 6-year old boy in our clinic told his father that a recently arrived uncle, from Jordan, who was a young man, was "drinking beers" and smelled of alcohol. His mother confirmed this. The father was very embarrassed to have this issue revealed in front of the therapists and said it was not possible that surely the boy was confused because his brother knew very well that drinking was haram (forbidden). The father became very upset as the boy insisted that he was telling the truth and finally told him to stop talking and that there would not be any further mention of this; the boy remained quiet.

Who Are the Families from the Middle East

The concept of "Middle East" is already a Eurocentric one, as it relates to the proximity to Europe, as opposed to the "Far East," which includes Japan, China, Vietnam, etc. There is considerable diversity that is often overlooked, both in terms of religion, cultural practices, beliefs, ethnicity, worldviews, etc. It is impossible to make a sweeping description of all the cultures and people who live in the Middle East. There is considerable diversity in religion, as the Middle East contains people who are Christian, Jewish, and Muslim. There are several varieties of "Christian," such as Roman Catholic, Maronite Catholic, Protestants, and others.

Shortly after the death of Mohammed, The Prophet, Islam split into two branches, Shiite and Sunni. Countries like Iran are predominantly Shiite, as well as portions of Syria and Iraq; others are predominantly Sunni—the majority of Muslim denomination in Saudi Arabia, Pakistan, and Kuwait. In principle there is no conflict between them, but in "radicalized" segments, one can accuse the other of being a "false Islam."

In countries like Afghanistan, Iran, Pakistan, and many others, individuals of different denominations coexist with various degrees of acceptance, tolerance, or conflict. They often speak different languages with a "dominant language" for the country. In Iran, for example, there are other multiple minorities and subcultures such as Kurds, Lors, Blutch, Jews, and Arabs (Mortazavi 2006). In addition to these major distinctions, within one ethnic group there may be "tribes" in some of these countries. Tribes consist of large groups of people at times remotely related with similar ethnicity and beliefs and who conceive themselves as belonging to a larger group, which grants some benefits and obligations. There may be rivalry between tribes over importance, influence, power, etc. It is necessary to keep this in mind because saying one is "from Iran" could say very little, and the family may identify itself further according to ethnicity, language, tribal affiliation, religion, etc.

Arabic is a language first and foremost, and any one of the ethnic groups could speak Arabic. But it also denotes an ethnicity: people from the Arab peninsula and colonized areas elsewhere. Berbers, for instance, the original inhabitants of North Africa (who call themselves Mazid, i.e., free people), were colonized by the Arab and Muslim caliphates and may speak mostly Arabic (the older generations speak Berber), but they are not "Arabs." Only around 20% of the Muslim population in the world is actually Arab (Lawrence and Rozmus 2001).

Like many other parts of the world the Middle East has a high proportion of young people. It is estimated that 40% of the population in the "Middle East" in general is under 15 years of age (Warnock Fernea 1995). In this chapter we will put emphasis on families who are influenced by Islam. This brings an additional issue, as many countries which are not in the Middle East practice the religion of Islam, such as in China; many countries formerly form the Soviet Union, Malaysia, and others in Southeast Asia, as well as Europe, North America, and others.

Influence of Religion on Middle Eastern Families

In families who identify themselves as Muslim, there is a continuum of adherence to the traditional religious practices and rituals, as is the case also with Jewish families. Some adhere to all the religious beliefs and practices, while others only respect certain rituals and celebrations while not carrying out all the religious obligations. Still, the religious beliefs inform parental values, what they want to transmit to their children and their philosophy of parenting. In Islam, there are multiple obligations and practices which influence everyday life.

The world Islam is rooted in the word "obedience" and seems to denote the principle of obeying a number of prescriptions and proscriptions in everyday life, which impact issues like meals, prayer, management of money, the family routine, the work area, and many others. Of course, this does not mean that most families adhere strictly to all the rituals that the religion would traditionally require, and many children of Muslim immigrants in Europe and the United States will try to develop their own identity separate from the practices of their parents (Vedder et al. 2007). Moral reasoning is strongly influenced by the religious precepts of Islam; these, for instance, dictate the prohibition against lending money with interest, the obligation to provide assistance to the poor and to offer hospitality to strangers, as well as being faithful and truthful and practicing self-control. These values may be in contrast with the values that are commonly espoused in industrialized capitalist countries, such as self-interest, greed as the dominant force in business, and finding ways to increase profits at all costs.

Some Common Islamic Values and Taboos

Patriarchalism

Having said that there are multiple models of what a family is in the Middle East, a common theme is patriarchalism. This applies generally to Jewish, Christian, and Islamic families, particularly the more traditional ones, in which men have the final decision on many important family matters and the housewife has more of an advisory and nurturance role. It is well known that in many Muslim countries, women have many restrictions on how to dress, going outside particularly if unaccompanied, and in the possibility of accessing certain occupations or professions. This principle of male authority or preeminence influences many issues, such as family dynamics and the different roles of girls and boys.

Marriage

In the traditional or more observant groups, according to the *Qur'an*, a marriage is a contract, mostly between the families of those who marry, wherein the marriage may be arranged by the family or by mutual consent. In the most

traditional groups, a man can marry up to four women, provided he can support them and that the earlier wives agree to the marriage. In reality this is done much less commonly. Due to social pressures, divorce is not as prevalent as in the West; however, it is acknowledged as a solution, and sanctioned by Islam, to marital problems, and a woman can initiate the divorce for cause.

Marriage between cousins is possible and in some groups even encouraged. This has generated a problem of consanguinity and higher prevalence of some genetically transmitted disorders (Bittles 2001). Marriage between fairly close relatives is also sanctioned in Judaism, in the Zoroastrian belief system, and in many areas of the world, as in South India (e.g., in the Dravidian tradition in Pondicherry), Pakistan, and Japan. It is really a widespread preference, which is now discouraged in the West. In the United States it is practiced by the Amish, Mennonites, and Samaritans. Indeed, it has been estimated that a little over 10% of all marriages in the world are between second cousins or closer consanguinity (Bittles and Black 2010).

As for Islam, even though these marriages are in reality preferred in many areas, they are not encouraged by the *Qur'an*. In any case, consanguinity is associated with higher rates of miscarriages and birth defects. Also, homozygosity is thought to be the mechanism by which some congenital diseases and malformations are more prevalent in consanguineous marriages, some as childhood glaucoma and bilateral retinoblastoma. The same applies to mild and severe mental retardation (Bittles 2001; Bittles and Black 2010).

If there is a divorce, women often may not be able to obtain the custody of the children, albeit in some countries they do. The marital relationship may be different from the one in the West, in which the husband and wife are considered as intimate lovers, best friends, kindred spirits, life companions, and whose members try to renew their relationship constantly. In the traditional Muslim family, the woman is more likely to reveal her problems and worries to other women, such as her sisters, cousins, or close friends than to her husband. The same applies to him. The closest relationships are with people of the same gender. This is important when assessing the "quality of the marriage." It would be difficult to impose on a man the duties and expectations that are now common for men in nuclear families in Westernized communities. The parents of the husband and the wife are very important, and families prefer, in general, to have regular contact with parents and siblings. Extended families are preferred by most people, and the grandparents or aunts and uncles exert a guiding role and provide some of the monitoring or discipline of the children.

Role of Women

Women are in general, like in most cultures, in a status that is less preeminent than men (Karmi 2005). However, in countries like Iran, a woman can inherit property and be the head of the household, but not so in other countries. The husband is the head of the family and it is expected that he would be the main source of financial support. If he cannot be, the woman's father or the older son, if capable, may be the main support. In the more traditional sectors women have much less authority than men and are socialized to respect the man as having the "last word" on most issues. Also, girls are raised to be obedient and to silence their opinions if they differ from those of the authority figures in the family. At times, the older generations have more weight in their opinions than the parents. This is a part of the social order, and most families operate in this way. Women may think this is the way "things are" and accept their role as natural.

Cleanliness

This is a prominent issue in Islam. A clean body is thought to contain a clean soul. Before prayers, the person has to make ablutions as a cleansing maneuver, if possible cleaning the nose, ears, eyes, hair, and feet. The slightest "soiling" alters this cleanliness. The baby also has to be clean for purposes of purity of the soul. Women and men

have to be clean before praying, and strict hygienic rituals are necessary even before prayers. Any soiling or dirt nullifies the prayer. There is a clear demarcation between "inside the house" and outside. Generally people do not wear shoes inside the house as they are dirty, and animals that are considered unclean, like dogs and other pets, generally are not acceptable inside the house.

The Pregnant and Postpartum Woman

Pregnancy is a very momentous and vulnerable stage of the woman's life. Not being able to have children may leave her frustrated and there may be suspicions that God is not favoring her; the cause of the infertility may be thought to reside in the woman herself or be related to some punishment to her family's behavior. Motherhood is, like in most cultures, an essential part of the woman's role in the family (Shahawy et al. 2015).

The expecting woman is perceived as needing to be looked after carefully by relatives, mostly women, such as her mother, sister, mother-in-law, sisters-in-law, and friends. She may or may not use protective amulets in order to prevent the effects of negative influences such as the "evil eye" or the possession by evil spirits. A commonly used protection is a "Fatima's hand," literally a small hand palm, often made of metal, that is worn for protection, or a piece of metal that contains glass symbolizing an eye. Other dangers are manipulating certain objects that may symbolize death or being visited or even seeing a woman who has lost a baby.

The delivery should be preferably attended by a midwife or a woman physician, although if not available it is not considered forbidden. Modesty is very important in all circumstances and "in public," like in a hospital, the woman may prefer to wear a hijab even in the hospital bed. Women (and men) are expected to shave pubic hair and not to let it grow more than "a grain of rice" in length, as this is also considered against cleanliness. There may be dietary restrictions during the pregnancy or the delivery, so the hospital staff may have to inquire about what not to bring.

Traditionally there is a period of "confinement" postpartum of about 40 days (Nahas and Amasheh 1999), which is observed in many cultures outside the Middle East as well, but which is nowadays not followed strictly. This period is also considered vulnerable. The postpartum excretions may be considered "impure" and the woman may not go outside for a period of time.

If there are any medical complications, a Muslim family may be very receptive of the recommendations of the physician but may consult also with a religious leader who may give permission, sometimes through a written *fatwa*, to go ahead with the treatment or procedure. There is wide variability in what is considered acceptable, for instance, regarding the use of stem cells, the practice of autopsy of the baby that died, etc. If the baby dies in utero or is a stillborn, most parents would be against the notion of necropsy. The body is expected to be buried and fairly promptly, i.e., the next day after the death. Embalming is prohibited. The baby's face once he is prepared for burial should face toward Mecca, the sacred city in Islam, or at least to the right. In many groups women are not permitted to attend burials, but can visit the grave later on.

Contrary to what might be thought, Islam encourages the reliance on science and modern medicine. Indeed, during the Middle Ages, Islamic medicine was at the forefront of medical knowledge; the first hospitals in the world and the most advanced medical knowledge were developed in Islamic areas. In the present, most people rely on modern medicine and would seek the latest advancements for their diagnosis and treatment. In some countries religious authorities endorse and encourage through *fatwas* (authoritative opinions for believers of Islam) issued by clerics versed on Islamic writings and jurisprudence, while they might impose limitations on others, like tissue transplantation.

In Iran, the use of reproductive technology is growing, with many in vitro fertilization clinics. They are widely present in the Muslim world also. Sexual reassignment surgery is performed regularly.

Some health principles will be mentioned that are pertinent to our discussions. A healthy lifestyle is encouraged, and alcohol consumption is forbidden. Praying regularly is thought to help maintain mental health (the traditional practice is to pray five times a day). There are dietary recommendations: to eat in moderation and a prohibition to eat pork. During the lunar month of Ramadan adults are expected to fast from sunup to sundown, but pregnant women and children are excused from this expectation. Some women however may fast anyway, because of the belief that more blessings will be bestowed on the pregnancy due to this ritual (Gatrad 1994). A woman may also choose to defer the observance of Ramadan until after the pregnancy and "make up" the fasting then. It is unclear whether the fasting has any negative effect on the birth weight of the baby.

In public settings, mixing of women and men is discouraged. Traditionally people of the opposite sex should not shake hands. Also, eye contact is not recommended. In some families, the clinician, if he is a man, may be expected not to ask questions directly to a woman, but through a third person, like her husband, mother, etc. The right hand is considered "clean" while the left hand traditionally was used for toileting and to touch the feet, the genitals, and the feet which are considered unclean (Qureshi 2012).

If the woman has her baby in a hospital setting, she may be very expressive of her pain during labor, as the open expression of feeling, crying, and screaming in public are sanctioned to communicate pain. Also, many visitors may appear in the patient's room and bring gifts or food. The more visitors, the more the woman has prestige and is esteemed. It is also the duty of the relatives to visit those who are in the hospital.

Bringing cold foods or beverages is a taboo during the labor process and certainly in the postpartum. It might be preferable to question the person and her relatives what foods might be deemed acceptable. The husband or the relatives of the woman may bring a gift to the doctor or nurses and offer food or even money to the healthcare personnel, as this is customary in many places, and it should not be taken as an offense or an attempt to bribe.

Many people believe in the "evil eye" as the source of their ailments. Another belief is the penetration by spirits, the *Djinn's*, causing a person, like a pregnant woman, to be anxious, irritable, or depressed or to have hallucinations.

An expecting woman might strongly prefer to be examined by a Muslim physician and a woman if possible. If she goes to the hospital to have her baby, a religiously observant woman might be uncomfortable being asked to wear a hospital gown (which would be too revealing and against modesty) or to remove her *hijab*.

The world "*halal*" may be used to denote something permitted or clean by religious precepts, as opposed for *haram*, or forbidden.

In the case of migrant Muslim women in a very different cultural context, there may be enormous barriers to seek help, for instance, for depression. She may feel worried about discrimination, being misunderstood, having problems to communicate and to "admit" that she is not happy, even if she just gave birth to a boy. The migration adds to the usual stressors and brings numerous other ones, like finding a suitable living situation, access to healthcare, and feeling welcome in the new country (Bragazzi and Del Puente 2012).

Child-Rearing Strategies

In the Muslim tradition, when the baby is born, the father whispers in the ear of the child a sentence from the *Qur'an* "Allah is great and there is no other God but Him" (a ritual known as *Takbir* or *Azan*). The idea is that the first words the baby hears are from the *Qur'an* and the name of Allah. The father also may put a drop of honey or date paste on the lips or the soft palate, a ritual called *Tahneek*, suggesting a welcome into the world and future happiness. A black string with a prayer (called *Ta-Weeze*) may be tied around the baby's neck which is thought to be protective against illnesses, spells, and the negative effects of envy.

A mother may prefer to have a boy, in order to transmit the family's last name, family business,

etc., and like in other cultures, she might be somewhat sad if the first baby is a girl. This is not based on religion, as Islam places no higher value on boys or girls, and women are important to ensure reproduction.

Many families believe, according to the *Hadith* (a book second only in importance to the *Qur'an*, which contains *sunnas*, or the anecdotes and action of the prophet, and recommendations for everyday life), that the mother receives the reward of a good deed for every drop of breast milk she gives to her baby. An important issue is the need for privacy and the difficulty during breastfeeding in front of other people due to modesty.

A common belief, like in many other cultures, is that the colostrum has no nutritional value or is not pure (McKenna and Shankar 2009) and instead mothers try to feed the baby water with sugar or honey. In many families from Pakistan (and India) the baby is given *ghutti,* a herbal preparation thought to improve digestion. In order to favor milk production, special foods may be prepared, such as mixture of herbs and nuts, which is thought to be helpful to relieve back pain as well. In the postpartum stage, chicken soup is often consumed, and hot water bottles may be placed on the abdomen.

The baby may be swaddled and the clothes are carefully chosen for beauty to denote that the baby is "spoken for" or that he or she has someone to look after the baby and protect him or her as it is often done in rural Turkey (DeLoache 2000).

On the seventh day after the birth, some families practice a ritual called *Aqiqa,* or naming ritual. The baby's head is shaved and then the baby is named by a member of the extended family. The hair can be buried or thrown into a flowing stream. This is believed to protect the baby and the family from ill fate.

The mother or grandmother may massage the baby with oils, in the belief this will make him healthy and active. Sometimes this is criticized by well-meaning nurses.

If the baby is a boy it is expected he will have the circumcision several weeks after birth, performed by a Muslim doctor. Muslim religion does not prescribe any "circumcision" (genital mutilation) for girls, although in some countries it is practiced, i.e., Sudan and other North African countries.

Among Muslims in general, there is a belief in angels, as Christians do. However, there are also "evil angels" or evil spirits that may enter the house. Dogs in the house are considered dirty and may invite the presence of evil angels. There are various rituals to keep the "inside," i.e., the house, "clean" and free from the impurities from the outside. For the most part people do not wear shoes inside the house (which are also removed when one enters the mosque). Small babies and infants are considered more vulnerable to evil influences and to be penetrated by *djinns* or evil spirits.

If a baby shows much fussiness or is frightened, evil eye influences or the *djinns* may be suspected. The parents may go to a healer or a religious figure to have some verses of the *Qur'an* read to the child. The *Qur'an* itself is often thought to have healing properties for many ailments, as well as reading its contents to the affected person.

Regarding feeding of the infant, the *Qur'an* encourages breastfeeding, for approximately 2 years (Shaikh and Ahmed 2006), although many women may not do it for this length of time.

An issue to consider is the possible deficiency of vitamin D in the mother and consequently also in the baby. If a woman covers her whole body when she goes outside, she may get little exposure to sunlight, and this eventually may lead to osteopenia and low levels of calcium in women. In the infant, the breast milk can have the same low level of calcium and vitamin D (Shaikh and Ahmed 2006) and vitamin D may need to be supplemented for the baby. Weaning or supplementing feeding with other foods is generally permissible around 4–6 months. The *Qur'an* indicates it is the obligation of the father to support breastfeeding; if this is not possible, the child may be fed by a wet nurse by mutual agreement between the two parents. If two infants are nursed by the same woman, they are considered as siblings and when they grow up they cannot marry each other.

In terms of child-rearing, mothers and other women are the main caregivers of the child. The father's role is more in line with what was traditional in the West a generation ago. As the child gets older, as a discipline strategy parents emphasize moral reasoning explanations, as well as encouraging the child to obey and comply. If this is not effective, shaming and ridiculing are often employed as instruments of social pressure. Mothers, grandmothers, and other relatives may participate in the discipline of children within the extended family and they also tend to induce guilt as a disciplinary strategy. In rural areas, informal discipline is also exerted by other people, many relatives, and neighbors.

Physical punishment is practiced later on in life, if the above-mentioned strategies fail. It is central for the family to maintain the principle of authority. A father may prefer to be respected or even feared, rather than loved and not be an effective parent. The mother is more likely to be warm but may threaten the child with withdrawing her love, with feeling hurt by the son or daughter, and also with telling the father what the child has done wrong.

Interactions with the Western Healthcare System

Here we describe some common health beliefs and traditional practices among people from the Middle East and emphasize those from Islam, which clinicians may consider when attempting to understand the health beliefs, common explanation for symptoms, and their influence in the perinatal period and early childhood (Inhorn and Serour 2011).

One important issue that women in the perinatal stage or with babies may fear is related to modesty: being seen by a male physician or nurses. An additional fear, particularly in the most recent times, relates to discrimination and prejudice against Muslims, a real problem in many industrialized societies in Europe and North America. A topic that has been noticed by many women is that the healthcare staff may advice the young mother that she should "not have so many children," which may make her feel unwelcome or judgmental (Gatrad 1994).

Interactions with the Mental Health Clinician

The prevalence of postpartum depression in a recent study in women from the United Arab Emirates (Green et al. 2006) appears to be about the same as that of other women in the world, around 20%. However, the more psychosocial stressors the woman faces, the higher the prevalence. Depression may have more somatic manifestations than psychological ones. The distinction between mind and body is not as clear as in the West, and the body is an instrument to express discomfort, anxiety, fear, anger, sadness, etc., so the distress may be manifested more as headaches, tiredness, backaches, exhaustion, etc. Particularly if the clinician does not have a relationship of trust with the patient, she may not reveal symptoms like sadness or loneliness. Also, the patient may feel compelled to give the "right answers" to questions, due to the need for social compliance. If asked, "how do you feel toward your father," she may say "Of course, I love him, because he is my father," and eliciting more negative feelings or confronting the patient may lead to a premature termination of any psychotherapy. A young expectant mother who was facing the prospect of a baby with a malformation was asked if she ever felt angry at God. She was horrified by the prospect and said: "One can never feel angry with Allah."

Also, the patient may exhibit what in the West might be construed as excessive dependence on her family, and this should not be considered prima facie as pathological, as this is the way that in all likelihood she has been socialized.

The Influence of "*Djinns*"

Djinns, like many other folk beliefs, are understood differently in various cultures in the Middle East; however the general idea is that these are evil spirits (also referred to as genies, lantiks, and

afrits). They are representations of bad influences in general (Lim et al. 2015). They are beings created by Allah: humans are created from clay, angels from light, and djinns from smokeless fire. As expectant women and babies are most at risk, one might expect that the woman, husband, or family might think the problem of crying in the baby, nightmares, or depression, anxiety, and panic attacks in the adult (Bragazzi and Del Puente 2012) or general irritability in the mother or in the baby are related to *djinns*. They could enter the person due to feelings of anger and envy in others, through the evil eye or simply bad wishes. This illustrates the need "not to boast" about the good fortune of expecting a baby or about the beauty of one's child, as this is perceived as dangerous.

Cases of postpartum depression and psychosis could also be ascribed to *djinns* tormenting the woman from inside. *Djinns* may make themselves visible in the form of a black dog, a cat, a scorpion, a bird, a goat, or a snake (Lim et al. 2015), which would be dangerous encounters for a pregnant woman or an infant. *Djinns* are thought to be able to travel at very high speeds through air, and they are very tall with eyes set vertically (Drieskens 2008). Indeed, *djinns* live in their own world and have their own lives and problems, and sometimes this world interacts with the human world (Camelin 1997). They have lives similar to those of humans and have physiological and sexual needs, including having children. They also live in the houses of humans and prefer to live in dirty places, damp, and dark, such as bathrooms, slaughterhouses, ponds, and rivers.

A young bachelor might unwittingly marry a *djinn*, who would preempt him from marrying anyone else or from having sexual relationships with another woman. *Djinns* that interact with children are called Arwaah (spirits). Shaytan (i.e., Satan, the Devil) are evil djinns, and the worst ones are called Maarid, demons. Some Muslims believe that every child comes to the world with a *djinn* companion (Lebling 2010), called a *hide* or *qarinah*, which may induce the child to act well or badly. Babies up to 2 years are thought to be able to see the *djinns*, but older ones and adults normally cannot see them.

A pregnant woman or a baby suffering even with physical complains or who has problems with emotions can be diagnosed as having the *djinns*. They can be the cause of irritability, conflict, depression, hallucinations, and even of marital discord and people falling into temptation. Fire spirits in particular are the cause of genital bleeding in women, as well as infertility. The entering of a *djinn* into a person's body is a form of possession (Somer 2006). Dissociative states in women and men are also attributed to djinns. People try to prevent the possession by *djinns* by using incense when a baby is born and to burn it everyday in the house in the morning, as this makes them leave (Camelin 1997).

The treatment of possession by *djinns* in traditional form requires a religious person or a Qur'anic healer to read the appropriate *suras* from the *Qur'an* and herbal remedies. A somewhat similar condition, possession by a *dybbuk*, is encountered in the Jewish tradition in various countries. The manifestations are similar, depression, anxiety, malaise, or pains, but in the case of *dybbuks* the possession is by the spirit of a dead person which finds a body to manifest itself (Bilu 2001). An *ibbur* is the soul of a good person who died and "impregnates" the body of a living human being in order to complete a mission from his own previous life.

Another culturally related phenomenon is *worried* which may have various meanings (Karadaĝ et al. 2006); it may denote "scruples" and doubts about whether one observed religious rituals properly, such as prayers. It can have also the connotation of an internal voice seeding doubt about cleanliness, dirt, pollution, sexual themes, etc. It is similar to symptoms of obsessive compulsive disorder (Ghassemzadeh et al. 2002). Women are more likely than men to worry about cleanliness, purity, and contamination in themselves and in their baby. The condition of *worried* also may refer to a whispering by *djinns* inciting the person to do bad things; it is not truly a hallucination but more of an "internal voice" that is externalized as the evil spirits inciting the person to behave badly (Razak and Latif 2014).

It is generally somewhat difficult in a Western context to elicit the folk beliefs of patients and

families, because of the fear of being disregarded, considered superstitious, and dismissed as primitive and ignorant. Folk beliefs and theories are important guideposts in the patient's conception of her condition or the problem in the baby and the clinician would be wise to encourage the family to share their own theories about what is afflicting the woman or the baby. However, some families might fear that merely mentioning the evil spirits might make them reappear.

Therapeutic Interventions

In highly industrialized and "modern" countries, there is a need for awareness about the beliefs, worldview, worries, and previous experiences of the people from different origins they will encounter. Muslim families often experience the very busy and rather rushed style of obstetric and pediatric practices as inadequate. They may think that the doctor does not talk much to them or is not interested in them as a person (Reitmanova and Gustafson 2008). Families also may feel criticized because of their traditional practices, dietary constrains, or the reluctance to be in the presence of men even in prenatal classes in hospitals. It is important to have services that are responsive to these issues, with a "cultural mediator" and not to lump "all Muslims" or "all people from Sudan" in one category. It is necessary to attempt to be respectful and to individualize. The violation of important cultural or religious taboos is as meaningful to these families as for a Christian would be to break an important ritual, like not permitting a Baptism for a Catholic family. It is necessary for institutions and practitioners to develop an attitude of acceptance and understanding the worldview of those they are serving.

In clinical work with persons, like a young couple, from the Middle East, it is useful to think of the family system in the broadest sense. A family therapy perspective, understanding who has the power for decisions and what balances and tensions exist in the family, might be more helpful to the individual who is the original "client." A "real world" intervention may involve the family as opposed to a very individualistic approach that is based on the self of the patient only.

Traditional healers have multiple local names; a traditional "doctor" can be a *taleb*, whereas a *marabout* is more like faith healer, who may be seen as a saint (Al-Issa 2000) or a spiritual guide.

When working with an individual woman or couple, it is useful to know that some religious Muslim patients may attempt to resolve a problem by looking in the *Hadith* or the *Qur'an* for a "similar problem" and to emulate how the Prophet solved it. In many communities, children are encouraged to memorize portions or all of the *Qur'an* and to know about the *Hadith*.

Also, some authors have suggested that instead of a transference based or psychodynamic psychotherapy approach, which emphasizes the uniqueness of a person's history and suffering, and the revelation of embarrassing thoughts or feelings, a cognitive and behavioral strategy might be more suitable. Nevertheless, it is clear that individual patients may wish to discuss traumatic events and relationships when they feel trust and are comfortable, for instance, a woman with a female therapist.

Many patients will, at least initially, expect to get concrete advice form the therapist, rather than to reflect on their thoughts and feelings. However, some degree of education and information about the strategies used in the therapy and an adequate therapeutic alliance should assist the patient to discuss material that they have never discussed with anyone, just as it is with Westernized patients and families.

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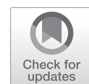
Part III

Cultural Variations in Specific Practices and Their Importance in Understanding Ourselves and Others



A Transcultural Model of Attachment and Its Vicissitudes: Interventions Based on Mentalization in Chile

11

Felipe Lecannelier

Attachment is a concept that was introduced in psychoanalysis and child psychology approximately 75 years ago by Bowlby (1969). It is a concept that is rooted in Biology, and in Evolution Theory as well as Ethology (the science of animal behavior). The basic concepts are that a baby will develop a preferential relationship with a few caregivers and will go to them for protection and nurturance, particularly when there is distress. The attachment behavior of the infant is observable after the sixth month of life and the "height" of attachment is observable readily around the first birthday of the baby. The infant will only go to the caregiver if the latter has been sensitive and responsive to the needs of the child. As soon as the infant establishes contact with the caregiver he or she will feel reassured and the stress will diminish quickly.

In terms of research, there is little research based on direct observation of the attachment patterns in naturalistic environments, despite the fact that Ainsworth made her initial observations with mothers and babies in Uganda (Ainsworth et al. 1974). There are multiple studies looking at attachment patterns based on the "strange situation" which is the basic research paradigm in the scientific literature. However, little can be said about "naturalistic" patterns of responsiveness by caregivers and behavior by the infant, which may or may not be strongly influenced by culture.

When one looks at the "strange situation," a cultural issue comes to the fore. In some cultures, babies around one year of age never have been around a stranger, while in others the infant has been in a child care center and is used to the presence of people that are not his immediate primary caregivers (mother, father, grandmother, etc.). It is possible that if one applies the research protocol of the strange situation, babies with less exposure to strangers might exhibit more distress upon separation and might get more upset. They may be more difficult to console after the separation which may be experienced as very stressful for such a child.

A further question that has been explored in the literature is whether infants who spend time in child care settings might have more insecure patterns of attachment than children that are not exposed to such extensive daily separations. It appears that prolonged hours in day care, and when the facility is inadequate or the caregivers do not respond to the signals of the child, this might alter the behavior of the infant at least in the child care center and might have a negative effect in the security of attachment of the infant in general. From the few studies available, it is hard to derive many conclusions about different cultures and their practices.

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Here, we focus on an intervention program to foster the development of secure attachment and caregiver sensitivity in a South American country, Chile (Lecannelier, 2012).

Until 15 years ago, early childhood was a neglected topic in Chile (and across South America) (Raczynski 2006) with scarce development of research, intervention, and public policies. Models focused on early attachment and sensitive caregiving were not included in prevention programs used in the diverse contexts of children's lives (public health, nursery school, kindergarten, hospitals, and others). Nevertheless, this lack of awareness and sensitivity to this fundamental stage in life started to change with the implementation of the child protection system called *Chile Crece Contigo* (Chile Grows with You), whose purpose is to provide an integrated social protection system for young children and their families from pregnancy to 5 years old (Infancia 2006). This national system (which is a law promulgated by the Chilean congress) offers a wide variety of services that include assessment and intervention, information, and material resources for children and their families that receive public healthcare assistance (70% of children in Chile). Social agents and political actors began to consider this topic as a priority and understand the urgency of early intervention for children and their caregivers at an economic, biological, socio-emotional, and cultural level (Heckman 2006; Narvaez et al. 2013; Polan and Hofer 2008; Shonkoff and Deborah 2000).

Here, we review main programs that have been implemented nationwide, aspects of the process of implementation, and level of impact (Lecannelier, 2014d). The nucleus of the intervention model used for all the programs is represented in the acronym AMAR which stands for Attention, Mentalization, Self-Mentalization and Regulation.[1]

[1]A.M.A.R means TO LOVE in English.

Theoretical and Empirical Bases of the AMAR Model

Survival and Emotional Security

As the "Ultra social beings" (Hrdy 2009) humans require the development of a sense of emotional security provided by others (Bowlby 1969; Cassidy and Shaver 2008; Lecannelier 2006a, b, 2009; Sroufe et al. 2006). When confronted with stressful or threatening situations the infant will innately tend to look for the protection of an adult "who is bigger, stronger, wiser and kind…" (Bowlby 1969). This early attachment system exists in a regulatory intersubjective space. The success of the efforts will lead to a sense within the child (and caregiver) of emotional security.

There are six main determinants that influence on infant emotional security:

1. Stability (continuous permanence of caregivers and no prolonged separations or frequent changes in the caregiving environment)
2. Continuity (amount of continued time with the caregiver)
3. Specificity (existence of a limited number of significant caregivers)
4. Predictability (in environmental habits and regulation strategies by caregivers),
5. Commitment to caregiving (understood from the perspective of caregiver investment or level of resources that the caregiver invests in the development and survival of the child)
6. Acknowledgement, regulation of stress (use of caregiving strategies that don't trigger feelings of threat and danger from the caregivers).

These conditions are summarized by the term Environment of Evolutionary Adaptedness or EEA (Bowlby 1969; Schore 2013). When the caregiving environment is lacking significantly in these characteristics, the infant experiences less emotional security and will deploy a wide range of [defensive] strategies to regulate personal and emotional bonds to re-establish security.

An external observer may consider these strategies as insecure or pathological, but from the child's experience they are adaptive modes (according to available internal and external resources) that reflect a best effort attempt to seek security in the world and with others (Lecannelier 2013a).

The purpose and rationale of the AMAR programs is to re-establish (or strengthen) adequate levels of emotional security in the infant (especially in stressful situations). The achievement of these aims requires that the caregiver develop specific capacities. From the perspective of the AMAR model this is applied using what we call the "Respectful Care System" (Lecannelier 2016).

Emotionally Secure Respectful Care System (CRESE[2])

During recent years (Small 2002; George and Solomon 2008), this type of care has received several names such as Positive Parenting (Rodrigo et al. 2007), Attachment Parenting (Sears and Sears 2001), and Attachment Focused Parenting (Hughes 2009). We proposed an extension to these notions with our concept "Respectful Caregiving System," in the sense that emotional security does not only come from parents (although it usually does) but also from alternative caregivers (e.g., infants in child care or institutionalized infants), from educators (preschool educators), or even from institutions (schools, hospitals, early institutionalization centers) (Lecannelier 2014b).

This Respectful Caregiving System has a number of identifiable inter-locking characteristics (Lecannelier 2016, 2019). The first involve seeing the infant's distress signals as serving a bonding function—as if the infant is saying "I can't do this on my own, I need your help." The next principle of caregiving is the need to "hold the child in mind," i.e., the child's expressions of stress need to be legitimized, accepted, understood, and valued (Hughes and Baylin 2012). Tied into this task is the caregiver's need to recall the child within him- or herself. The adult should, above all develop a mental/emotional attitude to "keep the child's mind in mind" (Bateman and Fonagy 2011; Midgley and Vrouva 2013). This attitude must, again, be used to empathize with, and understand (rather than control), the behavior and reactions of children (Hughes and Baylin 2012; Siegel and Hartzell 2013). This mental attitude of empathy and mentalization leads to an emotional and cognitive stance that operates under an ethical decree of "*do not do anything to children that you would not like done to you.*" Finally, stressful situations, or the immediate aftermath of distressful situations, are the appropriate moment to establish respectful care: on the one hand, it enables the regulation of an appropriate manner for children's reactions and behaviors, and on the other it allows for adults modelling diverse socio-emotional learning strategies (self-regulation, emotional understanding and expression, communication with adults, how to handle interpersonal conflicts and others (Denham and Burton 2004)). Therefore, stressful situations are the best moments for significant learning of socio-emotional strategies (Massie & Campbell, 1978) that go far beyond using verbal and cognitive instructions (Dozier et al. 2015; Lecannelier & Zamora, 2013; Lecannelier et al. 2010).

Elements of the AMAR Model

The AMAR model was inspired by established attachment-informed intervention programs, such as *Biobehavioral Catch-Up* by Mary Dozier (Dozier et al. 2005, 2006; Bick and Dozier 2013); *Minding the Baby* by Arieta Slade (Slade et al. 2005; Slade 2007), *Mentalization-Based Treatment* by Peter Fonagy and collaborators (Bateman and Fonagy 2011: Allen and Fonagy 2006); *Video-Feedback Intervention to Promote Positive Parenting* (VIPP) by Femmie Juffer, Marian J. Bakermans-Kranenburg, and Marinus van IJzendoorn (Juffer et al. 2007), *Circle of Security Project* (Cooper et al. 2005; Powell et al. 2013), and programs on Socio-Emotional Learning (SEL) in preschool education (Denham and Burton 2004).

Four core capacities are promoted by the AMAR programs as shown below in Fig. 11.1:

Attention is listed first as attending or observing is the first requirement for any learning or relearn-

[2] In Spanish, C.R.E.S.E also sounds like "grow".

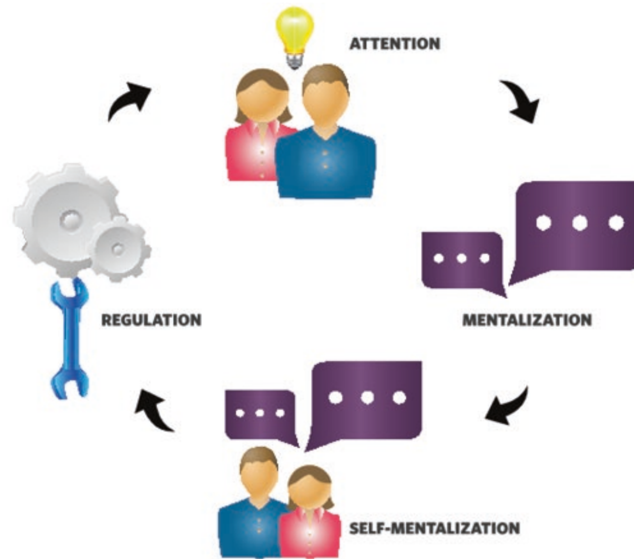


Fig. 11.1 Four core capacities

ing. The process of paying attention on the observable processes of behaviors and reactions of the child, especially during stressful moments, noticing the infant's non-verbal, verbal, and temperamental processes with the goal of recognizing the individuality of his experience (Ainsworth et al. 1974).

Mentalization is a procedural cognitive and emotional skill (i.e., there is no voluntary control) oriented to explain and understand the behavior of others by inferring and attributing mental states (Baron-Cohen et al. 2013; Bogdan 1997; Fonagy and Target 1997; Lecannelier 2009; Oppenheim and Koren-Karie 2012). It includes thinking about:

What the child may be thinking in stressful situations (emotional states).
What the child may be thinking or imagining or remembering, etc., (mental states).
What the child may need and express through his/her behavior and reaction to a stressful situation (what we call the "adaptive behavioral function").

This mentalization activity must be carried out with a positive attitude and a willingness to never a priori infer negative actions ("what the child does is manipulating") or discredit ("he/she is an aggressive child"), being self-referential ("you are crying just to annoy me"). Other responses are making the child feel guilty ("if you cry no one is going to love you"), making him or her feel threatened ("if you don't calm down I am going to punish you"), ridiculed ("don't cry like a baby"), rejected ("I won't take you in my arms if you have a tantrum"), or use psychological prescriptions ("learn to control your behavioral disorder").

The aim is to "understand the child from the child's point of view and not the adult's" without falling into negative attributions (Bateman and Fonagy 2011; Lecannelier 2014a).

Self-mentalization as the third principle. It is required by every adult in the caregiving system responsible for the child. It is the ability to reflect on one's own mental and emotional processes. The aim is to develop the capacity to identify and recognize what happens internally when one is in front of a child and he/she is reacting to a stressful situation (Fonagy et al. 2002). What it may trigger within oneself, and the need to understand this interactional process without acting on the triggered impulses. The development of this ability enables the adult to differentiate and separate with greater clarity one's emotional states from the child. Several studies have shown that when this ability is taught to caregivers, their impact on

the development of socio-emotional abilities increases (Denham and Burton 2004).

Regulation is the fourth capacity. This can be down-regulation (in case of children that are overwhelmed with stress), or up-regulation (in case of children that are highly inhibited and need to express their emotional states) (Gross 2015; Thompson 2015). The goal is to apply strategies that: (a) decrease the level of stress in the child; (b) help the child to develop skills for understanding and regulating emotional expression in ways that promote socio-emotional learning, (c) provide a message of safe haven.

The first three abilities (attention, mentalization, and self-mentalization) are the "mental training" needed before adults start to carry out a meaningful and lasting regulation behavior. This intervention strategy must be more than a simple application of a behavioral technique or general advice on child rearing since attention/mentalization/self-mentalization inevitably enables a visualization of the child's *individual* needs and mental and emotional processes.

Implementation of the AMAR Program Through Chile

The "experts" do not carry out a direct intervention with the caregiving system and the infants during the implementation of the programs; instead they train professionals and non-professionals (psychologists, educators, social workers, caregivers, parents) so that change can be generated by the people who interact daily with the children. It promotes empowerment of less expert people who, from the child's point of view, have a higher value in terms of survival and availability (be it in the home, nursery school or kindergarten, an institutionalization center, a foster family, etc.). With times these strategies will become an integral part of a culture of respectful care. The intervention can be adapted and integrated to the culture of each context or institution (for a review, see Lecannelier 2019).

Given evidence that continuity and constancy are vital to the successful implementation of interventions, especially in high-risk populations, (Berlin et al. 2008; Greenberg 2005), the AMAR interventions have a duration of 4–8 months. This continuity and constancy is maintained throughout the training and supervision sessions on-site and off-site. There is ample flexibility around the number of sessions per program, depending on the context where the implementation takes place, economic variables, availability of caregivers' time, characteristics of the group under intervention and other factors specific to the reality of each location.

We use videos to show the various situations so that implementers can learn in an experiential way the contents of the program. These include patterns of attachment, mother–baby interactions, stressful situations in infants, and different way to regulate stress.

AMAR-Caregivers Program (AMAR-C)

This strategy was originally intended as an intervention for institutionalized babies in orphanages, as in Chile, like in many Latin American countries foster care was rarely used (0–24 months) (Lecannelier and Hoffmann 2007). There is ample evidence about the negative effects of early institutionalization (Maclean 2003; Dozier and Rutter 2008; van Ijzendoorn et al. 2011; Bakermans-Kranenburg et al. 2011; McCall et al. 2008; Zeanah et al. 2005), in Chile, the institutionalization of infants at an early age is a public policy that has been applied massively. As a first step of intervention in these settings, a manual was elaborated for the caregivers to develop skills and encourage vocalization, eye contact, and physical contact (massage technique, for example), and the ability to identify difficulties in attachment and temperament (Lecannelier and Hoffmann 2007; Lecannelier et al. 2014c). A second version was subsequently implemented in highly vulnerable nursery schools in the city of Santiago, Chile (Lecannelier and Jorquera 2010).

A third version of the manual was funded by the Chilean government and disseminated at a national level in two different contexts

(Lecannelier et al. 2014b): (a) incarcerated mothers living with their children (during their first year of life) in all prisons in Chile; (b) institutionalized infants (0–24 months) with difficulties in nutrition and development.

Implementation Process

- The duration of the intervention is variable. The number of sessions can vary from 12 to 23 sessions once a week.
- Intervention procedures. The implementation of AMAR-C is carried out in the daily context of the infants' lives. (1) Training facilitators: for the professionals that will carry out the direct intervention with child caregivers who interact daily with the infants (mothers, professionals from nursery school o alternative caregivers). These professionals are called "facilitators," and are generally psychologists, social workers, or educators with specialization in the infant development and intervention. (2) Process of raising awareness: to generate consciousness of the relevance of the intervention to achieve better commitment, motivation, and adherence to the intervention. Facilitators coordinate meetings with caregivers; (3) Implementation stage: consists of weekly sessions carried out by the facilitators for the adults in charge of the children. In each session, the Attention-Mentalization-Self-Mentalization-Regulation skills are learned and practiced. A team of "experts" supervises the facilitators every 2 weeks. A pre-post assessment process includes the use of instruments to measure variables of the adults in charge of the infants (level of stress when caregiving, psychiatric symptoms, and beliefs on child rearing and infant development). Also we look at variables in the infants (general development and socio-emotional development). Evaluation of the attachment and caregiving system (security and attachment patterns and disruptive maternal communication), and of the general caregiving context (resources, caregiving routines carried out by the personnel, language, activities, interactions, and so on); (4) Technical transference process: a strategy was implemented to train two to four professionals to be trainers and ensure the continuity of the program and its dissemination to other locations; (5) recommendations for public policies.

Main Intervention Strategies

Attention

Develop attention to non-verbal processes related to attachment between the infant and caregiver (vocalization, eye contact, emotional contact, proximity, affective holding, affection, proximity seeking, and need to be calmed down).

Develop attention to disorganized behaviors in attachment (based on the ADS-III scale).

Develop attention to temperamental processes in the infant or style of temperament.

Mentalization

Develop the capacity to mentalize using the mentalization guide (worksheet).

Self-Mentalization

Develop the capacity to identify emotional processes related to the bond with the infant by observing videos and carrying out practical exercises.

Develop self-care habits for the adults when caregiving.

Regulation

Develop the use of massage techniques for the children.

Develop the use of strategies to calm crying.

Develop the use of interactive play.

Develop the use of stress-regulating strategies (Time-In and Emotional Education).

Impact of the Intervention

The empirical information showed: (1) a positive impact on infants and caregivers. Improvements in the levels of social orientation, emotional reactivity, activity, and orientation to object in the institutionalized children. The insecure patterns of attachment had a development significantly similar to the secure styles, after the intervention (Lecannelier et al. 2014a, b, c; Lecannelier 2019). The nationwide implementation in prisons and early institutionalization centers did not allow for a control group or randomized selection due to ethical regulations at government level. However, improvements in pre- and post-intervention were found in Disruptive Maternal Communication and quality of the general caregiving environment (Lecannelier et al, 2007);

Impact on public policies. Our program promoted to develop evidence on a national level about the status of infants in early institutionalization. Also, progressive change toward early de-institutionalization in favor of foster care. Third, an increased awareness of the improvements and changes in regulations on cohabiting in incarcerated mothers who live with their babies. In Chile, as in many other countries, mothers can have their young child while being imprisoned.

AMAR-Educational Program

The main objective of the AMAR-Educational Program is to promote Socio-Emotional Learning (SEL) through the attachment between educators and students in preschool children between 2 and 6 years of age. Evidence has shown that it is not only important that the child learns cognitive content but also social and emotional skills (such as expressing, regulating, and understanding one's own emotions and others); social abilities (developing empathy, respect, and esteem for others and their diversity); responsibility (conflict resolutions, develop awareness and respect for school, family, and family members). Other goals are to instill self-discipline, self-regulation, ethical, and personal responsibility (capacity to reflect on one's own behavior and others behavior). The social goals include an involvement with peers, develop friendship, cooperation and negotiation at work, to learn to give and receive help (Denham and Burton 2004; Lecannelier 2013a, b; Webster-Stratton 1999; Zins et al. 2004b). This is known as Socio-Emotional Learning (SEL). Children who develop a good level of SEL during the first years of life tend to have more and better friends, are more loved by their peers and teachers, have better communication, and resolve conflicts in a more flexible and adaptive manner. These children also show more prosocial behavior, are more empathic and manage better emotions like anger and frustration (Denham 1986; Denham et al. 2002; Saarni 1999). Adequate SEL is a potent predictor of academic performance both in preschool and school ages (Wang et al. 1997; Zins et al. 2004a). Also, educational institutions that promote SEL programs have students with less emotional problems and high-risk behavior (Payton et al. 2000). Yet the implementation of the strategies that promote SEL requires that the educators generate a "stress free environment" (Denham and Burton 2004; Lecannelier et al. 2008). If children do not feel secure, confident, and protected in the educational context and with their educators, any SEL activity will not be learned significantly and could have negative effects (Lecannelier 2013b; Lecannelier et al. 2008).

Consequently, the AMAR-E (educational) proposal follows a different direction; it does not focus on cognitive content, but adopts the premises of the attachment theory. This means that any SEL methodology should be implemented based on the enhancement of secure attachments with students and their educators (if the child does not feel secure in the educational context, it will be difficult to display their cognitive and motor capacities). Evidence has shown that children develop different attachment styles with their teachers (Sroufe et al. 2006; Howes and Smith 1995), and the pattern and quality of the attachment can differ up to 30–55% to that previously developed with the mother (Howes et al. 1988). A good quality of attachment between teacher and student is related to the development of empathic and prosocial behavior in the classroom. Children show less irritability and isolation and develop better skills to regulate interpersonal conflicts

(Howes et al. 1994; Mitchell-Copeland et al. 1997) and improve academic performance (Pianta and Howes 2005). The consequences of this rationale are enormous because it is a reformulation of the role of preschool education as a decisive instance for the present and future development of children. It also implies a change in the conception and management of stressful behaviors in children (tantrums, fighting, taking things from others, crying, isolation, etc.) from being considered as “undesirable obstacles to learning” that must be punished and extinguished to considering them from an attachment/mentalization perspective.

In such a setting, the child’s emotional security is a priority. Since this can only be achieved through attachment with educators, the proposal presented here is that SEL should be developed on two levels: (1) using the Attention-Mentalization-Self-Mentalization Regulation skills in stressful situations and (2) using a series of strategies to “teach” the young children a wide variety of socio-emotional skills.

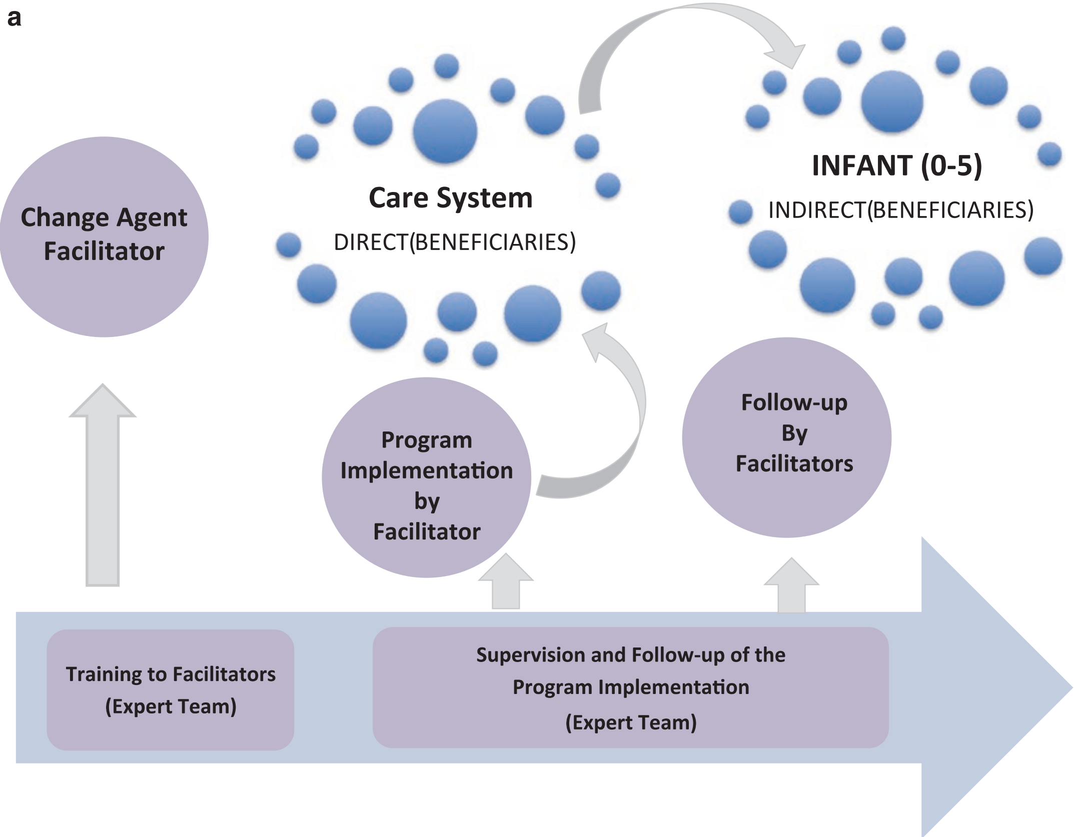
Program methodology of AMAR-E: The average duration of the program is 7–8 months (or approximately one academic year). However, due to the scarcity of resources in some educational institutions a version of 12 sessions has been elaborated (one per week).

– Intervention procedure. The AMAR-E program is implemented directly with the teachers and other professionals in the preschools. The implementation stages are: (1) Training for the facilitators: they carry out the intervention and have to be professionals who work in the schools. The school principal agrees to select them with the following inclusion criteria: be a psychologist (or educator with specialization in infant psychology), be part of the staff of the school, and be motivated to participate in the program. Training, supervision, and implementation are carried out during all the process through this professional team who lead weekly training sessions with the educators. The only direct intervention of the experts with the educators is three times a year when they are observed in the classroom to monitor the progress of the intervention; (2) Raising awareness: generate an appraisal on the importance of the intervention and diminish possible resistance to maximize commitment, motivation, and adherence to the intervention. (3) Implementation stage: This is when the intervention itself is carried out. This process implies three levels: (a) a 2-h supervision sessions for the facilitators every 2 weeks by the team of experts; (b) weekly 1–2 h sessions led by the facilitators with the educators; (c) observation in the classroom by the experts, three times a year.

There is also an assessment process similar to the one mentioned before. For the educators (stress during caregiving, psychiatric symptoms and beliefs on child rearing and infant development). For the preschool children (mental health, general and socio-emotional development and psychological-physical aggressiveness and prosocial behaviors). The attachment and caregiving system (representations of attachment of the educators with the children and disruptive Maternal Communication is evaluated), and the general teaching/learning environment (resources, caregiving routines of personnel, language, activities, interactions, and so on); (4) Technical Transference Process to disseminate the program at a massive scale, a strategy was implemented to give advanced training to the facilitators to continue to implement the program in the next generation of students, supervise those that were already operating and disseminate to other educational institutions; (5) recommendations for public policies.

Main Intervention Strategies

The main intervention strategies for AMAR-E replicate the attention, mentalization, and self-mentalization foci identified in Fig. 11.2 and at the heart of all AMAR work. Interestingly, where the AMAR-E manual differs is in terms of the patterns of behavior and emotional dysregulation that the teacher must aim to regulate: These include the following:



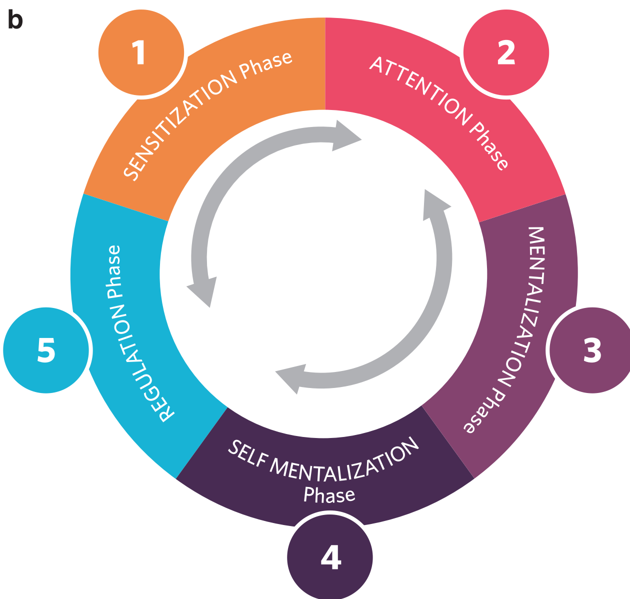


Fig. 11.2 Implementation process. (Original artwork by Ana-Marcela Maldonado-Morales)

Promote improvements in the educational environment.
Promote basic caregiving conditions that are necessary for the implementation of emotional regulation strategies.
Develop the use of stress-regulating strategies (Time-In and Emotional Education).
Develop strategies that favor the recognition and enable emotional differentiation.
Develop strategies to prevent bullying.

Impact of the Intervention

The impact of the AMAR-E program has been positive in various directions: (1) Increased awareness of the importance of SEL in preschool education; (2) The implementation was carried out in five cities in Chile, funded by the Chilean government. Around 500 children in early childhood were assessed through a pre- and post-design showing that relevant improvements were achieved in all the variables assessed. (3) At dissemination level: currently, the AMAR program is being disseminated in other cities and educational establishments increasing the awareness of its importance for education in Chile.

Attachment and Trauma Program **(PAT for *Programa de Apego y Trauma*)**

The purpose of the PAT program is the promotion of security in attachment and socio-emotional development through Respectful Care in institutionalized infants (0–48 months) that have suffered a complex trauma. Although exact empirical data do not exist in Chile, there are a high number of children in their early childhood and preschool ages who are in residential care due to chronic maltreatment, abuse, neglect, and other traumatic events provoked by their significant caregivers. Most of them have suffered multiple traumatic events, specifically of interpersonal origin and with disastrous consequences for the general development of the infant (Van der Kolk 2005, 2014). Complex trauma implies the multilevel understanding of the disorganized experience understood as a "traumatic constellation" that organizes all the infant's experience of being in the world, through its life trajectory (Lecannelier 2014c; Lieberman and van Horn 2008). Despite the fact that children during their first 6 years of life have a tendency to suffer a wide variety of traumatic situations, attention to this stage of early development has been far too scarce (Chu and Lieberman 2010; Finkelhor et al. 2007; Lieberman et al. 2011; Lecannelier 2018). Generally, the children have endured a cascade of impairing traumatic effects in development that begin at a prenatal stage (drug abuse, alcohol abuse, domestic violence depression, and a history of traumatic experiences) then in the postnatal stage (maltreatment, abuse, negligence, violence and multiple chronic stressors)since there are hardly foster homes, placement in an institutionalization (separation from caregivers, inadequate care, loneliness, and uncertainty). Unfortunately, it has also been shown that institutionalization usually constitutes a traumatic factor in itself due to the characteristics of such centers (high turnover of staff, a high number of children per caregiver, non-personalized care, absence of specific caregivers, infrequent cognitive and socio-emotional stimulation, stressful environment) (van Ijzendoorn et al. 2011). The PAT program is an intervention model that seeks to re-establish basic levels of emotional security by providing knowledge, conditions, tools, and strategies for all the adults in charge of the children. The aim is to enable them to understand, mentalize, respect, and regulate the traumatic experiences that these children experience almost daily. It is only through converting the centers into "systems of respectful care" that they can generate a positive impact in the lives and development of the children with complex trauma. This objective cannot be reached with a few hours of psychotherapy a week or with interventions that only focus on the child but through a change in the daily relational and emotional context of the children. On this point, it is important to highlight that the interventions empirically validated on trauma are usually focused on children from 6 years onwards (Blaustein and Kinniburg 2010; Cohen et al. 2006; Saxe et al. 2009). Those that do focus on infancy and preschool years are with infants that have, as a basic

condition, a significant and stable caregiver (Osofsky 2011; Lieberman and van Horn 2008). The PAT program is focused on the first 4 years of life and under conditions where parents or foster parents do not exist. Hence, the risk of intervening with these children with "trauma recovery psychotherapy" (common practice in Chile and other countries), when the child is still in a highly stressful situation and without a stable attachment figure, is an inappropriate practice. PAT also emphasizes that the most important thing is that the people who interact with the children can re-establish the minimum levels of security through respectful emotional relationship and that look to regulate/contain the traumatic experience.

Since this program has been implemented for less time than the others, it currently has a manual (Lecannelier 2014c) and a practical guide for carers in institutionalized contexts (Lecannelier 2015), which have been evaluated in three cities in Chile.

Program Methodology

– Duration. The program should last at least 12 sessions and at most, 22.
– Intervention procedure. The PAT program is implemented in the institutionalized centers where external facilitators work once a week with the institution's caregivers. Likewise, a number of professionals are selected and trained in these centers so that they can continue later on.

The implementation stages are the same as the other programs. However, since these centers have few resources, caregivers tend to have little professional training and the caregiving context of these children is usually highly stressful. Usually, there is a higher level of resistance to external programs so this stage must be very well planned and last longer than in the other programs (at least 1–2 months); (3) Implementation stage: The facilitators meet weekly with the caregivers (and other staff that work in the center and interact daily with the children). Each session is dedicated to learning and practicing the steps and strategies mentioned before.

The evaluation process before and after the intervention contemplates the use of tools to measure variables of the caregivers (level of stress when caregiving, psychiatric symptoms, and beliefs on child rearing and infant development), the infants (mental health, general and socio-emotional development, traumatic symptoms), the attachment and caregiving system (security and attachment styles and disruptive maternal communication), and in the general context of caregiving (resources, caregiving routines carried out by the personnel, language, activities, interactions, and so on.); (4) Technical transference p[rocess: in this case, the process was carried out as advanced training for a group of people with a professional degree that work all year round in the centers; (5) Recommendations for public policies: we want to implement studies on prevalence rates of complex trauma exposure in children to have more knowledge of the reality of traumatized early childhood and the posterior implementation and assessment of the impact of interventions (such as the Attachment and Trauma Program) in this population. Finally, another important objective of this stage is to end the silence at an institutional and national level for the thousands of children that suffer Complex Trauma.

Conclusions and Future Directions

My experience during the last 18 years goes from research in early attachment to the training and specialization in the field of early infancy and early intervention. Then, we work on dissemination of diverse intervention programs and finally conclude with the purpose of generating proposals and changes in public policies on early childhood. We face some challenges: most of the prevention and intervention programs have been implemented and assessed under controlled methodological and contextual conditions, where the interventors usually have high levels of specialization and count on financial support to enhance a favorable methodology and context (Berlin et al. 2007; Oppenheim and Goldsmith 2007; Lecannelier 2014e).

However, how does one transfer all this to real conditions? What happens when the interventionists don't have the required level of training and specialization? What happens when time and money aren't enough to reach the standards imposed by the team that created the intervention model? How can we maintain a constant level of reliability and low dropout rates in high-risk populations with a high turnover of professionals? What can one do when the people in charge of these real intervention contexts impose a series of restrictions related to the methodology, for instance, the use of videotapes?

During our dissemination experience, these difficulties were the norm rather than the exception. In this sense, Latin American countries usually have a very different way of progressing in dissemination processes, contrary to most countries in the Northern hemisphere. Yet in both regions there is a common challenge: the dissemination of interventions at a large scale (Greenberg 2005).

Our proposal is that our intervention manuals should contain, as part of the manual, a series of strategies on how to disseminate the intervention in real contexts. We have developed also a preliminary version of an intervention for foster families has been elaborated (AMAR-Familia, Lecannelier and Jorquera 2014), and a support program for adoptive parents (which was used at a national level), as well as an intervention for women during pregnancy (AMAR-Pregnancy).

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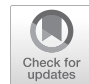

12 Culture, Pregnancy, and Its Challenges

Maria X. Maldonado-Morales

In this chapter, we will discuss challenges faced by generally heterosexual, cis-gendered women during pregnancy and in the postpartum period, particularly difficulties faced by women outside of the dominant United States culture, but we also explore cultural issues in other areas. Many of the barriers and problems of immigrants in the United States are also faced by immigrants in Europe, as in the Netherlands, Germany, Sweden, etc. (Schoevers et al. 2010). We will discuss problems for women who have recently immigrated. Also, there are "second-generation" immigrants, that is, women who have been raised in the United States, but whose families are from another country. Many complexities can arise from the collision of these cultures. We will touch on the challenges of balancing work and home life, the cultural issues related to dealing with a loss of a child, and lastly the importance of social support during the perinatal period. We illustrate some points through case studies from clinical experiences.

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Challenges for Pregnant Women from Diverse Cultural Backgrounds

A pregnancy can bring families together and joy to the parents and loved ones. Family culture shapes how a woman views her pregnancy, and how a family reacts to the pregnancy. In the United States, according to the Census Bureau, from 2011 to 2015, 13.2% of individuals were "foreign born," out of 323,127,513 people, meaning more than 42,000,000 individuals (US Department of Commerce 2016). In several European countries like Italy, Spain, Germany, and others, there is a recent influx of refugees and immigrants from North Africa and the Middle East due to poverty and armed conflicts.

The figures mentioned above for the US represent only the individuals that were counted in the Census Bureau, meaning there are millions of others who did not complete the census. It is estimated that in 2015, there were 11 million unauthorized immigrants in the United States, from many different countries (Jens et al. 2017). The reason for thinking about these totals is to consider the many different cultural beliefs and practices that coexist in the United States, like in many industrialized countries, and thus the many different views that can come together in a family, and healthcare settings, particularly at the time of pregnancy, delivery, puerperium, and in caring for the infant. For many families, the birth of a baby is something that is awaited and

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celebrated. However, during the pregnancy and the time after, there can be differing opinions on how the woman should care for herself, should care for baby, and for her new family. For some women, this advice comes from their own mothers, and at times from their mothers-in-law. The following is a case about tension between both families.

The following case vignette addresses these topics of how to balance personal and cultural beliefs, and the familial tensions that can arise as a result. The features of the case illustrate tensions in families that can be observed all over the world in which extended families have a strong involvement with new parents.

Vignette 1: Tensions with In-Laws

Ofelia grew-up in Peru and met her husband Felipe at the university in Lima. They married after several years of dating, and together they moved to the United States so that they could continue their studies in Engineering. Neither Ofelia nor Felipe had many friends in the United States, and so they relied heavily on each other, occasionally receiving visits from their respective families.

Ofelia has a close relationship with her mother, Julieta, and is able to discuss her thoughts and feeling with her mother. She shared feelings of anxiety and fear about becoming a mother, as well as the frustration with physical discomfort and morning sickness from the pregnancy. Ofelia's mother offered advice on how to manage the nausea and backaches, having had four children of her own. Felipe would hint at some of Ofelia's troubles to his mother on his nightly phone call to his parents, but was cautious to share too much, as he knew his mother could be quite forceful with her opinions and advice. Felipe's mother, Dolores, would constantly remind Ofelia via telephone calls, to avoid stress or extreme emotions as they might harm the baby, and thought that continuing to work might be too much stress for her. She strongly advised to avoid "susto" (fright), which could cause part of her spirit to leave her body. She also encouraged Ofelia to avoid handling knives, and to make sure she did not eat any cold foods, such as ice. She should also avoid cold winds, as they may also harm the pregnancy. Felipe and Ofelia listened, but didn't pay particular attention to the advice.

During Felipe and Ofelia's courtship, Ofelia had a generally positive relationship with Felipe's family. Ofelia and Felipe both lived with their respective parents until they were married, and only a few weeks later moved to the United States, so they had few interactions with their families as a married couple. Ofelia had grown up in an affluent home. Her father, Ricardo, worked as a prominent businessman, her mother, a homemaker, raised her brothers and sisters who all became working professionals like Ofelia. Felipe's family lived comfortably, but was not as affluent as that of Ofelia. Felipe's family ran a small business, so his father, Pedro, was at work most of the day, while his mother remained at home caring for the children and cooking the meals. As the oldest child and only son, Felipe was not expected by his parents to learn to cook or clean, but rather to focus on his studies. Felipe's mother was particularly doting of her son and would often tease Ofelia before their marriage that she would have to learn how to cook so she could be a proper wife and care for Felipe.

Both Ofelia and Felipe's parents wanted to be present for the birth of their grandchild, and so both sets of parents arrived in the United States the week of Ofelia's due date. All stayed with Ofelia and Felipe in their small two-bedroom apartment. There were several hushed arguments between Felipe and his parents and Felipe and Ofelia as to whose parents would be allowed in the delivery room. Ofelia wanted only her mother and Felipe. Felipe had no particular opinion, only he did want to be there himself, and wanted to ensure Ofelia felt comfortable. Ofelia's mother wanted to be in the room, but felt uncomfortable that she should be the only person apart from Felipe. Felipe's mother felt that she definitely should be in the delivery room, as this was her first grandchild, her son's first baby, and felt it extremely unfair that Julieta (Ofelia's mother) should be allowed in but not she. At the time of delivery, Ofelia and Felipe asked their nurse to

ensure only Felipe and Julieta were in the delivery room. Nothing was said explicitly to Felipe's mother ahead of time for fear of causing an unpleasant scene or even an argument.

Ofelia's delivery was long, and an emergency Cesarean section was necessary, but a healthy baby girl was born, whom they named Isabel, after Ofelia's late paternal grandmother. All of the new grandparents were at the hospital, and they all doted on baby Isabel. Ofelia's father had to return to Peru for his work a few days after Isabel's birth, but Julieta would remain for the next several weeks to help her daughter with the baby, and with Ofelia's recovery. Felipe's father also returned to Peru for his work after the baby's birth, but Dolores decided she too would stay for several weeks to help.

Upon Ofelia and Felipe's return home from the hospital, they found their home had been rearranged and objects moved around by Dolores, who stated she felt this was a much better arrangement for their things. Ofelia had trouble finding things she had set out for herself and baby and began to feel frustration toward her mother-in-law. Ofelia wanted this time after the hospital to be for herself, her husband, and her new baby, and had expressed this to her mother before the birth, and so Julieta tried to ensure to be helpful, but to also allow the new family time of their own. Felipe had not had this conversation with his own mother, and so she felt her presence was important in every moment involving her son or her granddaughter. Dolores was very traditional in her beliefs on how to care for a woman who has given birth, and she made this known to everyone.

Dolores quickly took control of the kitchen, cooking every meal, stating she knew how to cook and care for a family, "unlike others in the home," meaning Ofelia and her mother, who were not particularly talented in the kitchen. Dolores promulgated that Ofelia could have only hot foods, to begin the healing process for her surgery and her womb, and so was very strict on the foods she allowed Ofelia to eat. Ofelia didn't really want to eat hot foods in the middle of hot summer months, but didn't want to offend her mother-in-law. Julieta would try to reason with Felipe's mother, but many times this led to marked tension and uncomfortable silences in the apartment, and Julieta leaving the room to avoid an argument.

Ofelia was feeling very uneasy with the tension in her house, but also noticed that she was feeling much more irritable and sensitive than she had before giving birth. Ofelia started to feel easily and constantly tearful, quite sad, with insomnia and little appetite. Julieta didn't want to overwhelm Ofelia with questions about her behavior, so she quietly observed while trying to comfort Ofelia when she could. Julieta had to return to Peru after a few weeks due to her own mother's failing health, leaving Ofelia missing her mother, and worried about her grandmother.

Dolores expressed her concern about Ofelia very overtly, constantly asking Ofelia how she was feeling, how she was sleeping, and strongly encouraging her to eat throughout the day. Dolores was constantly preparing teas and hot drinks for Ofelia to promote appetite, sleep and well-being, and would constantly remind Ofelia that her crying was bad for the baby, that this would cause the baby to become colicky and tearful, and would curdle her breast milk, causing malnutrition in baby. Dolores would diagnose baby with colic and reflux when Isabel was fussy, or immediately declare the baby was tired or hungry if she cried at all. Dolores would rush to hold Isabel, leaving Ofelia to have to ask to hold her own daughter. Ofelia and Isabel were forbidden from going outside for the next 40 days after the delivery, or "cuarentena," as Dolores believed that Ofelia's body and reproductive organs were still in a fragile state, and that she and Isabel could become ill, or chilled, thus insisting in wrapping up Ofelia and baby. The danger of "mal de ojo" (evil eye) was also a concern for Dolores, which can cause baby to have symptoms of illness, caused by other people's jealous thoughts and looks.

Neither Felipe nor Ofelia subscribed to Dolores' beliefs or fears, but also did not want to cause additional tension in the home by disagreeing openly or arguing, they did not want to offend Dolores, especially since she was offering help and was away from her own home.

Ofelia found that she was not feeling better after several weeks, and in fact was feeling increasingly less like herself, and becoming more irritable and less patient with her mother-in-law. Ofelia was still attentive and caring toward baby Isabel, but found herself constantly thinking about Isabel's well-being, safety, sleep patterns, and wondering if she was bonding properly with her due to Dolores' constant interference. Ofelia found herself feeling resentful and angry toward Felipe, who she felt was not defending her properly against his mother, and who never dared to contradict his mother. Ofelia became more disrespectful in her responses toward her husband, and increasingly toward her mother-in-law. Ofelia finally gave way to her emotions when she saw Dolores preparing a tea for baby Isabel, who had some gastrointestinal issues, and was sure the tea would cure the pain. Ofelia began to yell at Dolores, unleashing weeks' worth of grievances and frustrations. Felipe watched as Ofelia cried and berated his mother but said nothing. He too felt frustrated in this situation but was not sure how to navigate the relationships with his mother and his wife. Felipe felt caught between wanting to not offend his mother, and siding and caring for his wife.

Dolores was appalled by Ofelia's words and tears and angered by the situation. She rebutted by stating that she had only tried to help, that her son and his wife were ungrateful and ill-mannered. Through her own tears, she said all she wanted was to spend time with her only grandchild while she still could, and that she had held her tongue about feeling extremely slighted that baby Isabel was named after someone in Ofelia's family, instead of Felipe's, and especially not after her own name. Dolores stormed out of the apartment and returned several hours later, and without saying a word, locked herself in her bedroom, where she could be heard calling her husband and loudly communicating to him what had transpired earlier in the afternoon.

Ofelia apologized to Felipe for yelling at his mother, but Felipe stated that he too had been feeling frustrated but did not know how to verbalize these feelings. Ofelia told Felipe of all the difficulties she had been experiencing, and the feelings of sadness and irritability, and Felipe stated that perhaps Ofelia would benefit from seeing her physician.

This case calls attention to several points that commonly arise in such scenarios. Having little support in a new country can cause women to feel isolated and frightened. Tension between women and mothers-in-law is not uncommon in many cultures, but anger can rise when temperaments and beliefs of individuals collide. Women may feel more irritable and sensitive during the postpartum period, due to lack of sleep and the transition into motherhood. In many cultures, it would be openly expected that the daughter-in-law obey and be totally deferential to her, with the additional problem that the young woman has to "swallow her feelings" to not break social expectations and never verbalize her rage, let alone defend herself.

Inequalities in Access to Health Care and Barriers to Obtaining Health Care

The perinatal period from pregnancy to postpartum can be a time of joy, as well as of challenge and trepidation. In the United States, like in most countries, pregnancy is seen as something positive and joyful, but also as a time for special care to be provided to the woman and embryo. In many areas of the world affected by poverty and scarcity of services, pregnancy can be quite dangerous and there is high perinatal death and infant mortality (Kurjak & Bekavac 2005). Indeed, around 500,000 women die every year from perinatal complications, and about 98% of the deaths occur in underdeveloped countries. The Centers for Disease Control in the United States encourage women to ensure that they are consuming folic acid and accessing vaccinations against whooping cough during the pregnancy, as well as avoiding smoking, alcohol, and certain medications (During Pregnancy 2017). Women are also advised to visit their doctor to monitor their health, as well as that of baby, and to receive support as they become mothers. Though women are encouraged to access prenatal care, as they

progress through their pregnancy, many women do not, for a variety of reasons, which can affect their health, as well as possibly increasing the incidence of low birth weight infants and preterm birth (Phillippi 2009). For many women, it may be due to lack of transportation because they live in an area where the nearest physician may be several hours away and lack of health insurance. For many, the cost of medical services may be beyond their ability to pay, the wait times at the clinic are too long, and here may be little to no access to childcare while the woman is at her visit (Phillippi 2009). Low health literacy in communities may also be a contributing factor. Women might lack the knowledge that prenatal care is not only available but also important for their health. A woman may be unaware of her pregnancy, or purposely hiding her pregnancy, or have another illness such as depression which limits her motivation to seek support (Phillippi 2009). Distrust of the healthcare system can also be a contributing factor, the fear that something could happen at the hospital, that one could become ill by going to see the doctor. There may be fear of medical procedures, such as drawing blood or pelvic exams, could cause a woman to avoid prenatal care (Yanikkerem et al. 2009).

For women who have recently immigrated to the United States, or whose culture may be questioned when visiting the physician, prenatal care may not be readily accessed. Immigrant women often face barriers of language, literacy, and not understanding the medical culture or expectations (Schoevers et al. 2010). Women who do not have a legalized status in the host country, may also have an additional fear of being reported to the authorities, and so may be frightened to visit a hospital or official building.

Challenges for Pregnant Women from Diverse Cultural Backgrounds

Family culture can shape how a woman and the extended family view the pregnancy. In the United States, according to the Census Bureau, from 2011 to 2015, 13.2% of individuals were "foreign born," out of 323,127,513 people, meaning more than 42,000,000 individuals (US Department of Commerce 2016). This figure represents only the individuals accounted for in the Census Bureau, suggesting that there are millions of others who did not complete Census. It is estimated that, in 2015, there were 11 million unauthorized immigrants in the United States from many different countries (Jens et al. 2017). The reason for thinking about these totals is to consider the many different cultural beliefs and practices that coexist in the United States, and thus the many different views that can come together in a family, particularly at the time of pregnancy.

For many families, the birth of a baby is something that is awaited and celebrated. However, during the pregnancy and the time after, there can be differing opinions on how the woman should care for herself and the baby, and how she should manage in her "new family."

Many women experience what are referred to as the "baby blues" after delivery, while other develop postpartum depression, anxiety, and even psychosis. In the United States, up to 1 in 7 women are predicted to develop postpartum depression (APA 2016). The World Health Organization (WHO) reports 10% of pregnant women and 13% of women who have recently given birth experience a mental disorder, generally depression. In developing countries, WHO reports nearly 16% of pregnant women and 20% after birth will experience a mental health disorder (WHO 2016a). All those figures are probably underestimates due to the social stigma associated with "admitting" that one is unhappy or depressed.

Depressive symptoms develop after childbirth in approximately 10–15% women, and if they are severe, may require treatment with medication or hospitalization (Boyd et al. 2006). Depression during pregnancy can negatively impact maternal–fetal interaction, and thus lead to poor mother–infant attachment (McFarland et al. 2011). Mental health services are not always readily available in communities, and thus many women struggle with finding a provider, as well as finding affordable care. In the "real world," most of the mental health interventions occur informally, by nurses, peers, relatives, pastors, etc.

When a woman has limited social or emotional support, if she struggles, there may not be someone there to notice or realize that she is feeling increasingly lonely. Migrating to a new country can bring many different changes and new experiences. Many women living in the United States may feel isolated and alone due to a language barrier, as well as being separated from their parents, extended family, sometimes partners and children in their home country. In the majority of cultures, support from family members is given to the new mother and baby, and many times mothers, mothers-in-law, and respected female elders provide care and information so the new mother can learn how to care for herself and her baby (Dennis et al. 2007). Help and support from family can be extremely beneficial, but can also be the cause of tension and stress, as seen in the case vignette presented above. At times, traditional beliefs from the home country can be dismissed for the practices of the dominant culture, which can lead to people feeling their culture and beliefs questioned. Some holidays may be difficult to celebrate or rituals that used to be widely performed in the home culture now seem irrelevant or embarrassing.

Behaviors During Pregnancy

Women around the world have beliefs about behavior that they should avoid, or complete to ensure that they have a healthy pregnancy. There are some similarities in beliefs and customs, despite geographic distance. In preparing to be a mother, many cultures encourage family to come together to help the woman during this time, and prepare for baby (Dennis et al. 2007). In Japan, some women return to her parents' home about 8 weeks before delivery to be cared for by her mother until about 8 weeks postpartum, a practice called *Satogaeri bunben* (Dennis et al. 2007). Women in China and in Mexico are discouraged from lifting heavy objects, handling sharp objects, and attending funerals (Brathwaite and Williams 2004; Maldonado-Duran and Brockington 2011). Thai women were traditionally discouraged from making preparation for baby, such as prepare diapers or baby clothes, as this could create bad luck, and cause the baby to die. Also, in the eighth month, it is traditional to have a magical shower performed by a magical healer to promote an easy birth (Liamputtong et al. 2005). For some women who practice Islam, increased eating during pregnancy is feared to lead to large babies, thus resulting in difficult deliveries. Many women will eat less during this time to have an easier delivery (Choudhry 1997; Ahlqvist and Wirfält 2000). The beliefs for what can cause loss or harm to baby vary from region to region, but ultimately the purpose is to ensure the well-being of mother and baby. For this purpose, women must adhere to traditional rituals and behaviors and avoid the "dangerous" ones.

Childbirth Practices

In the United States, childbirth practices are generally similar, as childbirth is commonly done in a standardized hospital setting. However, there are practices that are important to the delivery of the baby for many cultures that are not always able to fit into the model of a hospital delivery. Many women around the world have home births, and have support from family members, or traditional birth assistants, who may utilize traditional medicine. For some Zambian women, it is a taboo for her mother-in-law to see the delivery, as she should not see her daughter-in-law naked (Maimbolwa et al. 2003). Religion can also have an influence in the practice of delivery.

Muslim women generally prefer to have women supporting them through labor, such as mothers or mothers-in-law, and to have female medical staff. It is generally the religious custom that the first words the newborn hears are from the Qur'an, which should be uttered by the father or religious figure. Ideally, the baby should be cleaned and washed before this occurs. A less common tradition is that a well-respected person gives the newborn honey to lick, hoping that the good qualities of that person will be transmitted to the baby; it is well known elsewhere that this implies health risks (including infant botulism) (Gatrad 1994). For many women in Thailand, it is

important to deliver facing east, as this is the direction of light, rather than west, which is the direction of death. The woman's family and husband are usually present to assist with the birth (Liamputtong et al. 2005). The support of the family and community create a positive birthing experience for mother and baby, regardless of culture or country.

Behaviors Postpartum

Practices and beliefs about the postpartum period vary from one culture to another, but there are some similarities in practices. Many cultures encourage the extended family to come together to support the new mother, not only in caring for baby, but also in caring for her. Many times, the help includes household chores, preparing food, as well as teaching the mother how to be a mother (Dennis et al. 2007). Periods of rest, or restricted outings, are common, and can span for several weeks postpartum. These include Japanese, Hmong, Malay, and South African groups. Three to five weeks is encouraged in Korea, known as *sam chil il;* in Latin America, the 40-day "quarantine" (*la cuarentena)* and 40 days are also encouraged for women in India and Muslim women (Dennis et al. 2007). In China, one-month confinement is practiced, and women are to maintain a balanced diet to restore heat to her body (Brathwaite and Williams 2004), while in Myanmar women are confined to their home from 7 days to 1 month. To care for the newly delivered woman, it is customary to smear or drink turmeric to prevent muscle pain, particularly after eating the wrong food, for at least 1 week postpartum (Sein 2013). To expel "dirty" induced perspiration is sometimes practiced, and for the *lochia* as well as taking traditional medicine, uterine massage, and placing a hot brick on the abdomen to encourage healing of the body. Abstinence from sex is encouraged to last about forty-five days postpartum, to ensure healing of the body, and future fertility (Sein 2013). The resting period is important to restore the woman's body, as well as a time for a woman to rest and adjust to motherhood.

The balance of heat and cold is a concern prevalent in several cultures, the idea that women are in a cold state after birth because of loss blood, which is a hot state, and so the woman is encouraged to avoid drafts, bathing, washing her hair, feet and teeth (Liu et al. 2015; Lundberg and Ngoc Thu 2011; Sein 2013). Many cultures focus on cleanliness of the woman after birth. Bathing restrictions are common, particularly to maintain the balance between warm and cold. Sweating, however, is encouraged in some cultures, such as in Thailand and Guatemala (Dennis et al. 2007). Some women in Asian countries are given herbal steam baths one or two months after giving birth to restore health. Another practice is "roasting the mother," where a small fire is placed under mother's bed in a small container to restore her health and former figure by heating her body. Mothers or mothers-in-law care for the woman, and many times provide these traditional treatments (Lundberg and Ngoc Thu 2011). Several cultures find it important to bury the placenta to ensure that an evil spirit does not harm the mother or baby (Maimbolwa et al. 2003; Choudhry 1997). The tables below from Raman et al. (2016a, p. 92), describe some examples of rituals practiced during the perinatal period.

Examples of perinatal ritual practices in low- and middle-income countries

Author	Region	Ritual practice
Adams et al. (2005)	Tibet	*Bang gsol* ceremony, within the first 3 weeks of newborn's life, with ritual feeding of butter and barley flour, as prescribed by the Tibetan medical texts rgyud bzhi
Brunson (2010)	Nepal	*Sutkeri*, ritual pollution practice, involves reading of holy book *Swasthaani*, stops after performing *Nuaran* ceremony
Ejidokun (2000)	Nigeria	Kolanut ceremony to determine pregnancy
Iyengar et al. (2008)	Rajasthan, India	Delayed newborn bathing till *sooraj pooja* (sun ceremony)

Author	Region	Ritual practice
Kaphle et al. (2013)	Nepal	*Chau*, pollution practice, postpartum period of at least 2 weeks and also during menstruation, women do not go to kitchen, prayer room, temple
Khadduri et al. (2008)	Pakistan	Elderly male family member, recites *azan* (Muslim call for prayers), into the ear of ceremonially cleansed newborn, head shaving and circumcision ceremony at 7 days
Kwagala (2013)	Sabiny, Uganda	Charcoal powder and herbal extracts applied to the cord stump; placenta either buried in banana plantation or outside the house, or thrown into a pit latrine facing upwards by a trusted person
Zulu (2001)	Malawi	Child strengthening ritual to protect the child from becoming sick through contact with the fluids that parents produce when they have sex. *Chisaula* ritual, at resumption of menstruation after giving birth, salt can then be added to food

Examples of restrictive practices involving postpartum period with emic terms

Author	Region	Ritual practice
Bandyopadhyay (2009)	Bengal, India	Belief in ritual pollution after childbirth, isolation and segregation of the newborn and the mother for at least 21 days
Khadduri et al. (2008)	Pakistan	*Chilla* 40-day confinement with restriction in nutrition
Kwagala (2013)	Sabiny, Uganda	Seclusion for the mother and infant from 1 week to 30 days, prolonged sexual abstinence
Piperata (2008)	Amazon, Brazil	*Resguardo*, 40-day postpartum rest period, with specific dietary and work restrictions
Sein (2013)	Myanmar	Home confinement, abstinence of sex, behavioral restrictions including food, for 7–45 days
Strand et al. (2009)	China	*Zuo yuezi*, "doing the month." Postpartum women confined to room, severe restrictions on movement, exercise, daily activity, and food
Thapa et al. (2000)	Nepal	*Sukteri*, formal seclusion and dietary restriction from childbirth to about 30 days
White (2004)	Cambodia	Restriction on activity, movement and nutrition from 1 to 3 months postpartum, till sawdaye is mature
Zulu (2001)	Malawi	Postpartum bleeding period and sexual abstinence is followed by *Makhumbi*, in which mother, father, and infant bathe in water mixed with herbal medicine

Care for Baby

Providing care for baby varies even from family to family, but there are some similarities in how the mother is cared for by the family.

Traditionally in China, the baby is not to be dressed in used clothes, as the child can take on the characteristics of those who wore the clothes before them (including hospital gowns). It is discouraged to describe the baby as beautiful as the gods might take the baby away as a result of bragging about baby (Brathwaite and Williams 2004). Babies are very precious members of the family, and so parents and family members are worried about how to protect babies from harm.

People from many cultures are concerned about jealousies and curses, and malicious stares from strangers, many times called the evil eye (Maldonado-Duran and Brockington 2011).

Turkish families protect from the evil eye by wearing blue beads, written charms, praying, keeping a Qur'an in a room, wearing gold, and covering the baby in red muslin (Ozsoy and Katabi 2008). Families in India may have a fear of the evil eye, *nujur*, and thus admiring a newborn is usually discouraged because it can cause envy in others, and thus casting of the evil eye. Mothers tend to not be overly expressive with affection to their baby in the presence of others, including relatives. Families are also weary of physical examinations and weighing the baby, as this can also bring about jealousy and *nujur* (Choudhry 1997). To help ward off the evil eye, families place a mixture of black soot and butter on the baby's forehead in the shape of a dot called *kujul,* as well as keeping items made of iron under the baby's bed (Choudhry 1997).

Many Muslim families also have a fear of the evil eye. Families tie a black string around baby's wrist or neck, called a *Ta-weez*, which bears a prayer to protect from illness and spells to ward off the evil eye. On the seventh day after delivery, the baby's head is shaved, given a name, and a sheep or goat is slaughtered, this is called the *Akika (Aqiqa)* ceremony. The hair from the baby's head is buried or thrown into a stream, which is meant to protect the baby and family from future tragedies. A few weeks after birth, baby boys are circumcised to ensure the purity of his future prayer (Gatrad 1994). In Latin America, families are also concerned with the evil eye, or *mal de ojo*, and so babies are given amulets, red bracelets, or necklaces to ward off evil. In Mexico, it is common to wear a deer-eye seed, or *ojo de venado*, to ward off the evil eye (Maldonado-Duran and Brockington 2011). It is important for mothers and families to feel that they are keeping their babies and family safe.

Food and Nutrition

Nutrition during pregnancy requires a healthy diet that includes adequate intake of minerals, vitamins, and protein (WHO 2016b). Many different beliefs around nutrition and food are observed throughout the world. Food permissible during pregnancy may be different from those foods permitted postpartum. In many cultures, foods are classified as "hot" and "cold" based on the property of the food, and not necessarily to the temperatures of the food themselves (Dennis et al. 2007). This is particularly seen in Chinese traditional medicine, in the duality of forces of *yin* and *yang*: *yin* referring to coldness, darkness, softness, and femininity, and *yang* referring to heat, brightness, dryness, hardness, and masculinity (Dennis et al. 2007). The following are samples of particular foods and cultures.

Perinatal Period

Women are discouraged from eating certain foods to avoid fetal malformations, miscarriage, or early delivery (Brathwaite and Williams 2004; Liamputtong et al. 2005; Maimbolwa et al. 2003; Choudhry 1997). In many Latin American countries, satisfying cravings, or *antojos*, is seen as a way to satisfy the mother, and avoid negative feelings to be transferred to the baby (Maldonado-Duran and Brockington 2011). For Iranian women, the satisfaction of cravings is very important to prevent miscarriages, meet the nutritional needs and wishes of the fetus and provide satisfaction to the mother, particularly during the first trimester of pregnancy (Ahlqvist and Wirfält 2000). Some of these preferences for foods continue in the postpartum period, particularly in restoring the balance between hot and cold states, and how this nutrition affects baby's nutrition.

Food and Nutrition for Baby

The World Health Organization encourages mothers to start breastfeeding infants within 1 h of life, exclusively for 6 months, and up to 2 years of age (World Health Organization 2002). The majority of women around the world breastfeed for a variety of reasons, which can include tradition or access to other sources of food. However, some women do not abide by the recommendations to breastfeed exclusively or immediately after birth. Although it is encouraged by the

World Health Organization to feed babies immediately after birth, many cultures, including those in Latin America, believe the colostrum is not healthy for the baby, and breastfeeding is delayed (Dennis et al. 2007; Lundberg and Ngoc Thu 2011; Gatrad 1994). Mothers and families behave in the way they feel is best for their families, even if it does not align with recommendations for medical staff or global health organizations.

The above table from Raman et al. (2016b, p. 7) outlines some examples of healing foods and traditional medicine used by women in the perinatal period.

Challenges During Pregnancy and Postpartum

Women who do not have the support of family and friends feel very isolated, and are at risk for depression. Predictors of postpartum depression include prenatal depression, low social support, low partner support, poor marital relationship quality, single parenthood, low self-esteem, low socioeconomic status, stressful life events, unplanned or unwanted pregnancy, history of violence and/or trauma, intimate partner violence (IPV). Also, being born in another country with undocumented immigrant status (Valentine et al. 2011). Many immigrants find themselves in very vulnerable situations, which are exacerbated by pregnancy. This is particularly true if they have limited or no access to healthcare, resources, or

Examples of ethno-medicine/healing foods used by women during the perinatal period

Author	Region	Food substance	Effect
Adams (2005)	Tibet	Butter ingested by newborn *Chang:* warm barley beer ingested by mother	In order for child to have a clear mind and well-developed senses
Ayiasi (2013)	Uganda	*Waragi* local alcohol	Generally therapeutic, keeps infant's skin clear
Farnes (2011)	Ghana	Local herbs ingested by mothers	Prevents *sunsumyare* (spiritual sickness), promotes maternal, fetal health, prevents complications
Hadwiger (2012)	Philippines	Ginger	Protect unborn baby from *aswang* (evil spirits)
Lundberg (2011)	Vietnam	Pig's trotter with papaya or red bean and potato, meat and eggs	Enrich blood, help recovery, encourage expulsion of the lochia, stimulate lactation
Maimbola (2003)	Zambia	Traditional medicine applied to vagina	Prepare and widen the birth canal in pregnant women
Ngomane (2012)	S. Africa	*Mbita*, *Ritlangi*, *Mpundulo* *Mbheswana, roots of Xirhakarhani, boiled Dinda*	Strengthen and preserve pregnancy Induction, management of labor, and management of pain
Radoff (2013)	Guatemala	Teas and baths from grasses and trees, cypress, pine, oak, pear, eucalyptus	Stimulate labor, reduce postpartum bleeding
Raven (2007)	China	Ginger and wine Meat and eggs	Enrich blood, help recovery, encourage expulsion of the lochia, stimulate lactation
Sein (2013)	Myanmar	Turmeric, ingested or applied to skin	Prevent muscle pain and to prevent newborn from abdominal pain
Thapa (2000)	Nepal	Mustard oil, turmeric, eggs ingested	Regain energy post-partum, make womb strong, relieve pain
Theroux (2013)	Ghana	Bitter leaf, dandelion, *prekos*, *maringa*, *nim* tree, and *kontosi*	Prepare for labor
Wulandari (2011)	Bali	Tamarind, turmeric, cinnamon, clove, coconut Herbal medicines	Prepare for labor Improve maternal and infant health

aid in their native language. Recent immigrants, who are isolated in the new country, without family or other supports, and who do not know the local language, customs, or expectations of the new country.

The following case study illustrates the experience of an immigrant family, who do not have legal documentation in the United States, and the challenges this can add to an already stressful family situation.

A complicated pregnancy and birth can cause a lot of stress on the woman, and her family. An extended stay in the Neonatal Intensive Care Unit (NICU) can lead to tension between the couple who has to make decisions about their baby's care and health on a daily basis. If the couple has already experienced Interpersonal Violence (IPV) in their relationship, the stress of a NICU stay can exacerbate these issues. Legal documentation is a constant worry for individuals who do not possess such papers, and hospital stays can empathize these worries, particularly due to registering the baby and acquiring medical insurance, such as Medicaid.

Vignette 2: Interpersonal Violence, Documentation, and Complex Care

Lupita met Juan when she was 17, and though he was several years older, she began a relationship with him while they were both living in central Mexico. Lupita was aware that Juan had two previous children with another woman, but she was in love with Juan, so she continued her relationship. Juan worked at a mechanic shop but was having trouble making enough money to provide for his children, as well to give money to his parents and siblings. Several months into their relationship, Juan's cousin offered to help Juan cross the border into the United States with an opportunity for work and better pay. Juan decided to take it, leaving Lupita three months pregnant with their first child.

After several months of not hearing from Juan, Lupita decided that she should be with the father of her child and found a friend who would take her across the border. Lupita was nearly eight months pregnant at that time, and being a petite woman, her pregnancy was very apparent. Later, Lupita would reflect that perhaps being so visibly pregnant was a protective factor in keeping her safe from other men. Lupita had heard stories of women assaulted and raped along the journey, and she counted herself lucky that this did not happen to her.

When Lupita arrived in the United States, she contacted a friend, Susana, whom she had known since childhood. Lupita stayed with Susana for several months, not knowing where to find Juan, and at this point had her baby girl, whom she named Juanita. Lupita's delivery had been relatively easy and her baby was healthy and strong. Lupita had been very worried during the pregnancy about this, as she had experienced several episodes of hunger and thirst in her crossing. After the cuarentena, Lupita found a job at a local restaurant, and worked while her baby was cared for by Susana's aunt. Lupita tried to contact Juan for several months, and when Juanita was nearly two-years-old, Juan found Lupita. They began living together, and in three years, had two more little girls. Juan forbade Lupita to work, stating that it was the man's role to provide financially for his family, and that it was her role to remain home and care for the children. Juan had complete control of the finances and gave Lupita a weekly amount of money for the food and clothes for the family. Juan did not like Lupita to socialize with her old friends, particularly any male friends she had made while working at the restaurant. Juan was very jealous, and would accuse Lupita of flirting with other men. He wondered if she was being unfaithful, if she were to smile or have a conversation with another man. Juan would demand sexual intercourse from Lupita, even when she did not want to, and would at times force himself on her.

Lupita had been taught that it is the duty of a wife to do as her husband asks, particularly when relating to sexual relations, because men have "needs" that they cannot control. If the wife does not satisfy those needs, then he will go elsewhere seeking sexual satisfaction. Lupita's mother had taught her daughters this lesson from a young age, citing this as one of the reasons as to why their father had left their family when Lupita was very young.

During their four years together, Juan would work long hours, and at times not return home. Lupita would question Juan, which would result in fights about loyalty, and trust, and Juan would raise his voice and call Lupita terrible names. Lupita was told by friends from her work that they had heard Juan had several girlfriends and was constantly "cheating on her." Lupita confronted Juan about this, which resulted in him slapping her across the face, telling her that she had no right not question him about his needs. Their three daughters were present during the fights and yelling, and witnessed their father hitting their mother. Lupita decided to leave and go with her daughters to live with her friend Susana, who had helped her years before. Although Susana was willing to help Lupita, her house was small, and the three little girls didn't have a place to play or sleep in privacy. Susana urged Lupita to leave Juan for good, since they were not married, and he was unfaithful to her. Lupita felt torn, wanting to have their daughters grow-up with a father, something she never had, or leave a situation she knew was making her unhappy.

Juan finally found Lupita after a few days, begging her to come back to him, and saying that he would be different and things would change. Having no financial independence of her own, and three young daughters to care for, Lupita found herself returning to her relationship with Juan. This pattern of fighting, brief separations, and reunification continued for several years. Juan began consuming alcohol to excess, and would return home inebriated, and would get increasingly violent with Lupita. Lupita tried to shield the girls from witnessing their father's belligerence, but it was not possible. Lupita contemplated leaving Juan, but was not sure how she would be able to find a job without legal documentation that would allow her enough financial independence to care for herself and her daughters. Lupita had not finished high school and had limited skills for the workforce. She also did not know who would help care for her daughters, and ensure they were safe and cared for at all times. As her girls began school, Lupita began to worry more about her own documentation status in the United States. Lupita worried that she could be deported, and thus separated from her daughters. Juan finally "allowed" her to drive so that she could take the girls to school and to appointments, but Lupita was constantly worried she could be stopped by the police and arrested. Juan reinforced these fears, and would threaten that if Lupita were deported, the girls would be placed in foster care, with strangers, and that Lupita would never see them again. Enrolling the girls in school, making doctor's appointments, and filling out paperwork in clinics and the school increased her fear of being discovered, and thus deportation.

During this time of stress, Lupita discovered she was pregnant. She felt ambivalent about the pregnancy: partially happy to think of having a baby, but feeling uncertain if she could care for another child in her current life situation. Juan was becoming increasingly abusive, and their daughters were witnessing more of this. Lupita still felt nervous to seek prenatal care, because she feared the hospital would alert the police of her legal status, but found she was feeling very anxious about her baby's health and well-being, so decided to seek out medical attention.

At her twenty-week ultrasound, Lupita was informed that the baby in utero *had several health problems, including a ventricular septal defect and Trisomy 21, or Down's syndrome. Lupita was informed that the baby was a boy, and that he would spend several months in the neonatal intensive care unit (NICU), and would most likely require heart surgery after his birth.*

Lupita didn't know how to share this news with Juan. She thought Juan would blame her for the health issues of their baby. Juan had always wanted to have a boy, and blamed Lupita of having only girls. Lupita tried to explain the baby's situation in the best way she could, but Juan was indeed very frustrated, questioning Lupita as to what she could have done to cause harm to the baby. Juan wondered if Lupita had been outside during an eclipse (believed to cause birth defects in many communities) or perhaps someone had cast a spell using brujeria (witchcraft) to cause harm to the baby. Juan also accused Lupita of "cheating" and having another man's baby as an explanation to why this was happening to the boy

he had always wanted. After weeks of pleading with Juan to understand she had done nothing to harm the baby, he relented. However, he would still would bring up possibilities for reasons that the baby could have so many health difficulties.

Lupita did in fact blame herself, thinking that perhaps it was a punishment for not wanting the pregnancy initially, or for having a baby with a man who she did not really love, or for staying in a situation she should have left before this baby was conceived. Lupita had been raised Catholic, so terminating the pregnancy would have not been a possibility, but at the same time she began questioning her faith, wondering why God would send her a baby who could potentially not live past his birth.

Lupita went into preterm labor, and baby was born several weeks early via Cesarean section, and whisked away to the NICU. Lupita was unable to see her baby for the first few days of his life, and worried that he could die before she could see him. Juan asked that the baby be named after his own father, Pedro. Baby Pedro remained in the NICU after Lupita was released, and Lupita would go to the hospital every day to see him. Lupita spoke very limited English, but tried to communicate with the nurses and doctors as best she could, always inquiring after her baby's current state. Lupita began to feel increasingly attached to her baby, wanting to hold him when she could, and pumping breastmilk to feel that she was doing something for her baby, because she felt she had already failed him in so many ways. Lupita felt she was failing as a mother to her baby, because she couldn't take him home, and he was so infirm. She also felt she was failing her daughters, because she would rush from the hospital to pick them up from school, make them food, try to spend time with them, and then take them to school in the morning to return to the hospital. Juan would remind her that she was gone all day, and that he felt neglected, having to care for the girls on weekends when Lupita wanted to see the baby, and having simple meals prepared for him, rather than meals with several menu options. Juan's reproaches increased with time as the baby continued in the NICU, and his words became stronger and crueler. Juan felt that all of Lupita's time and energy were spent on the children, with nothing left for him, and so this justified his spending time with other women.

Lupita's friend, Susana, and her family would try to help Lupita as much as they could, by watching the girls, or by bringing food, but they too had their own set of troubles, and Juan limited access to Lupita. Lupita felt alone and isolated in the hospital, and though she was very attached to her daughters, felt that she had no support or help with them. Again, Lupita reflected that perhaps her relationship with Juan was not beneficial for herself, or her children, but if she left him, she had nowhere to live, no means of income, and no support with four children, one of whom would have lifelong health concerns.

After several surgeries, and several months in the NICU, baby Pedro was discharged home, with strict instructions for care. Lupita had to provide care around the clock, while still caring for three young daughters, and with limited support from others. Baby Pedro was able to continue receiving his medical care, as a citizen of the US, but Lupita was no longer able to access medical care outside of the window of her pregnancy due to her legal status.

Several studies have shown that parents of babies in the NICU may experience symptoms of depression, anxiety, and posttraumatic stress (Lefkowitz et al. 2010; Carter et al. 2007; Dudek-Shriber 2004; Shaw et al. 2006). Some studies have shown that mothers of babies in the NICU tend to feel more distress than the fathers, as they take on more of a caretaking role (Carter et al. 2007; Shaw et al. 2006; Lefkowitz et al. 2010).

In the current political and social environment, in the United States as in many other countries, it can be difficult for immigrants to navigate, especially those who are undocumented. Additional barriers arise when an individual does not speak the language of the services offered, and may not trust the healthcare system. It is difficult to find high-quality services in multiple languages, and an organization and practitioners that are culturally competent (Aguilar-Gaxiola et al. 2012). Feelings of loneliness, vulnerability, sadness, and even desperation can lead women to not take care of themselves, their children, and

may even lead them to a drastic action and behavior (Sumner et al. 2012).

Childcare or babysitters can be difficult to find for many women, particularly if they do not have many friends or family nearby. Of course, many young mothers do not have experience with strangers (i.e., babysitters) taking care of their children. Public transportation can also be challenging for families with young children, and can be costly in large cities (Vallianatos et al. 2006; Hill et al. 2011).

Loss in the Perinatal Period

Unexpected loss, miscarriage, stillbirths, and issues with fertility can be extremely challenging experiences for women and families. The following are vignettes of cases of women who have experienced loss.

Vignette 3. Stillbirth

Sana was concerned she had not felt much movement over the last week of her pregnancy. This was her first pregnancy, so she was not quite sure what she should expect. Sana and her husband, Ali, had only been married a short time, and so Sana felt very blessed that she should be pregnant so soon after marriage. Sana and Ali had chosen the name Shiza for their daughter, as is traditional in Islam to choose a name before baby is born. Sana felt some contractions for a few days, but Ali assured her that things were fine, and so Sana did not go to the hospital until close to her delivery date. Sana arrived at the hospital and the nurse could not find baby's heartbeat. Sana's delivery was induced, and a stillbirth baby was delivered. Sana and Ali felt extremely sad and wondered what could have caused this to occur. Sana felt extremely guilt, worrying that something she had done had caused this, and that she should have been to see the doctor sooner. Though Sana was clearly grieving and sad, the nurses were surprised that Sana did not want to hold the baby or want photographs taken. Sana and Ali explained that for them it was not necessary to hold the baby if the child was no longer alive, and to have a representation of the baby via photograph. They explained that it was important for them to have baby buried as soon as possible, and so they called their Mosque to have the body collected promptly, and declined an autopsy, in accordance with their Muslim practices. They felt that the death was maktub, or already written in the book of life.

The loss of a pregnancy can be a one of the most challenging things for a woman or a couple to face, and can lead to feelings of much grief, loss, guilt, anxiety, and self-doubt (Robinson 2011; Kersting and Wagner 2012; Crawley et al. 2013; Kersting et al. 2009).

As seen in the cases above, women, as well as men, can experience feelings of shame, self-reproach, or having done something wrong, and the majority of women feel as though they have failed in some way, or that their body has failed and betrayed them (Robinson 2011; Kersting and Wagner 2012). Some women may feel anger and jealousy when they see other women who are pregnant or have babies, and then feel guilt for having felt this way toward another woman (Kersting and Wagner 2012). For many people, turning to their religion can be helpful, as a way of allowing themselves to grieve and making some sense of the situation, as well as by having support from their religious communities (Kersting and Wagner 2012). Some couples may suffer some tension in their relationship in dealing with their own feelings related to the loss, as well as possibly experiencing symptoms of depression, anxiety, or posttraumatic stress (Robinson 2011) (Kersting et al. 2009) (Kersting and Wagner 2012). Perinatal loss is not a commonly discussed topic, and thus some women can feel isolated after experiencing loss, thus increasing the feelings of guilt and shame. If a woman is already socially isolated, a loss can increase the feelings of loneliness.

Clinical Considerations

Although cultures and beliefs systems may differ from country to country, at the core of the perinatal experience is the change it brings for women and their families. Women experiencing a repro-

ductive perinatal event can feel a range of emotions, from joy to sadness, but at times can feel isolated in their experiences, particularly if they are removed from their family and friends, cultures, and support systems.

The role of clinicians is to listen, try to understand, support, guide, and at times advocate for the individual or family they are serving. Systems in the United States, as well as in other countries, do not always modify or understand the importance of certain practices and belief systems, and these can be particularly important during pregnancy and childbirth. The birth of a child brings with it change, expected or not, and with it a mélange of emotions and reactions. The clinician can serve as a support system in navigating this change with the woman, and family, and having an awareness of what is important and significant to the woman and family will, hopefully, allow for a positive transition into a new stage for the woman and family.

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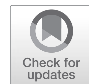

13 Culture Sleep and Its Vicissitudes in the Perinatal Period and During Early Childhood

Muhammad Farhan and Andrés Jiménez-Gómez

At first sight it would appear that sleep is a purely physiological phenomenon, something that our brain and body need in order to restore energy and to rest. As for the brain, sleep represents to engage in a very active process that perhaps is related to consolidation of memories and processing information obtained during the day. Nevertheless, as one starts thinking about the particulars of sleep, its duration, when people sleep, what conditions are necessary for them to do so, the question becomes more complex. Additionally, when one wonders what happens during sleep in the case of pregnant women or young children, immediately social and cultural issues come to the fore (Williams 2007; Jenni and O'Connor 2005).

Sleep and its features are strongly influenced by cultural practices (Williams and Bendelow 1998). Let us examine what we consider a very common and everyday practice: shift work. In many industrialized and poor countries, people work some weeks during the day, some weeks during the night or in the evening. What is the effect of this on their lifestyle and sleep? One can see the highly artificial nature of the practice if we were to compare it with the millennia of humans mostly "sleeping in the night" and the sleep–wake cycle that is maintained in most traditional societies, including perhaps a nap during the daytime.

In many Westernized areas, sleep is considered as a solitary phenomenon, something the individual does alone. This also applies to children, even very young ones. However, in much of the world this is not so. Sleep is not a solitary phenomenon, because people sleep in groups, or in small units (Super and Harkness 2013). This means that there might be different patterns of sleep and disturbances in different culturally determined sleep arrangements.

It might be useful to reflect on the fact that in the world of animals sleep is a very "costly activity" from the evolutionary point of view. It appears that all animals sleep, including fishes and reptiles, although usually not for long stretches of time, but during brief periods of "quietness" throughout the day. During sleep, animals are vulnerable to predation and obviously are not vigilant. Diverse animals have developed different strategies to ensure their survival to achieve sleep, which is essential to the homeostasis of the body. Some sleep for very short periods of time throughout the 24-h day, rather than in a circadian pattern. Many animals, like birds and mammals, sleep in groups, in physical contact with one another in the case of mammals and

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many birds. If someone is attacked in a larger group, the others realize this quickly and take protections. Another strategy is that one member of the group, as with some birds, is awake while the others sleep so that there is surveillance, and then a sign of alarm is made when a predator is nearby.

Cetaceans and some bird species sleep with only one brain hemisphere at a time. The alert hemisphere can keep partial watch of their surroundings, that is, one eye open and the other closed so there is no total vulnerability. Some migratory birds have developed the ability of sleeping while they are flying in long distances (McNamara et al. 2010).

Primates and humans sleep for a comparatively very long continuous period of time, mostly during the night: this is a "luxury" from an evolutionary point of view. They go through prolonged rituals in order to select a sleeping site (Anderson 1998), then to ensure their safety before going to sleep and waking up a few times during the night for short periods (McNamara et al. 2010). The precondition for sleep is safety and this may be something that many humans may find difficult to feel in: conditions of high stress, such as in neighborhoods in inner cities in the United States, for example, where there are shootings during the night, in high-crime areas, or in war zones.

Many primates sleep in groups so there is a higher chance of survival in case of an attack on a sleeping site, also they exhibit "cryptic behavior" to minimize the chance of being attacked at their sleep site during their repose. In humans there may be a biologically based bias toward sleeping in groups, in contact with another conspecific in order to increase the feeling of safety.

Culture, Pregnancy, and Sleep

It is generally accepted that the sleep of an expecting woman will change due to the processes taking place in her body. In the first trimester there may be more sleepiness and in the third, its opposite, very interrupted sleep. In many cultures this is accepted as a result of the volume of the baby in utero and its effect on the stomach and lungs, the urinary bladder, etc. As a result, the woman usually will have more interrupted sleep, she will wake up to urinate more often, and her breathing is somewhat difficult. She also will have to change positions often and may develop back pain and leg cramps.

There are other sleep difficulties that are not specific to pregnancy but when they manifest during this period, they may be interpreted as the result of extraordinary influences or additional factors. Panic attacks may appear during pregnancy and wake up the woman suddenly, as well as sleep paralysis and nightmares.

The Sleep of the Expecting Woman and Her Partner

Pregnancy is a time of increased risk for some sleep disturbances, particularly in the second half, with interrupted sleep due to the sheer volume of the uterus and its mechanical effect on other organs, such as the bladder or the digestive system and respiratory apparatus. Toward the end of the pregnancy there may be back pain, and the movements of the baby in utero wake up the mother. The evidence suggests that up to 90% of women in the third trimester have sleep disruptions (Wilson et al. 2011), with decreased duration of sleep phase III and IV, which is the reparative or restful sleep.

There is also an increased risk of restless leg syndrome, which may affect around 20% of women during pregnancy (Balendran et al. 2011) and is related often to iron deficiency. In areas with low access to vegetables and other sources of iron, this could further disrupt the sleep of women and their daytime function. The prevalence of restless leg syndrome increases with subsequent pregnancies.

Anxieties and Dreams

There is scarce empirical information about the common dreams of women during the perinatal period specifically (Margherita et al. 2015). A

recent study of women with previous perinatal loss found more anxiety dreams in the subsequent pregnancy (Van et al. 2004). Many mental health clinicians have the impression that pregnant women often report dreams of birth, of the course of the pregnancy (Dagan et al. 2001) and anxieties about the outcome. A recent empirical study found a similar pattern (Coo et al. 2014) in which there were differences between the antenatal and postnatal patterns of dreams.

In the Western world, dreams are now considered as something of little significance or not meaningful, which is a shift from past decades. In many areas of the world, women and the family pay close attention to the nature and content of their dreams, as they are thought to have a meaning. A woman could have an auspicious dream while pregnant, in which she dreams that the baby is beautiful, healthy, and everything goes well. However, many women might worry if they dream of certain topics or images, like knives, which might mean a disruption in the pregnancy in some cultures or dreaming about an ancestor or a person who died, who is taken to attempt to communicate with the pregnant woman. The dream might influence the name given to the child and how the baby is perceived.

A pregnant woman might be tormented by dreams of a posttraumatic nature. We often encounter this in persons who have suffered maltreatment and deprivation during their childhood. Women who experienced a very negative relationship with their mother, and now "they are going to become a mother," may experience scary dreams in which the baby dies, the mother mistreats the child, the baby is robbed, or disappears, etc. These are common anxieties in pregnant women, which in the case of one who has been traumatized can be exacerbated or intensified.

An exploration of women's dreams during pregnancy in Israel found an association between more unpleasant and anxious dreams in women who later developed postpartum depression, in comparison with women who did not (Kron and Brosh 2003). In several African cultures, dreams are considered as part of the life of a person in which he or she has access to the world of spirits. A dream with frightful content can be understood as an attack by spirits on the soul of the dreamer, which may lead to negative consequences in the health of the pregnant woman, or on the outcome of the pregnancy (Aina and Morakinyo 2011). The dream can also contain the encounter of the dreamer's soul with another person's soul, which attacks one of the dreamers (Gollnhoffer and Silans 1973) and brings about an "unnatural disease."

In many cultures, like in some African and Australian groups, it is thought that the spirit of the person leaves the body during the night, while the person is dreaming. It is important to wake the person carefully to give the sleeper time to regain her spirit, lest it gets lost (Musharbash 2013).

Sleep Paralysis

Sleep paralysis consists of a disturbance in which the person is "awake." In the sense that he or she can hear what is happening around, but cannot open the eyes and cannot move, so there are no external signs that the person is awake. It can last minutes, or in rare cases hours. At times it is very frightening for the sleeper, who cannot "get unstuck" from the inability to move and appear awake. Its prevalence in adults has been reported to be as high as 52% for occasional sleep paralysis experiences. In China, it is often interpreted as "ghost oppression" (Wing et al. 1994). In some traditional Chinese beliefs, the soul of a person is vulnerable to attacks during sleep, as it escapes the body. The ghost may attack the sleeper and paralyze her temporarily. Some sleepers report also a heaviness on the chest and even looking at the ghost of a woman holding a baby. Similar interpretations, ghost oppression (called *dab tsog*) are found in the Hmong immigrants in Wisconsin (Young et al. 2013). Other representations are the *Pandafeche* phenomenon in Italy (Jalal et al. 2015) which is thought of as a witch or a woman in the form of a cat. A demon attack during the night in Japan (*kanashibari*, which literally means being bound and unable to move) (Yoshimura 2015), and in Morocco and Egypt, an attack by *djinns* (evil spirits).

Sleep in Infants and Young Children: Are There Culturally Based Differences?

A somewhat unusual situation has been described in the Maghreb (usually comprehending Northern African mostly Muslim countries) (Jansen 2000) which here is referred to mostly for its symbolic value. It consists of the fetus "falling asleep" in utero leading to a protracted pregnancy, which lasts more than the expected 10 lunar months.

As for sleep in infants, most of the information available in the world's scientific literature is predominantly from industrialized countries, such as the United Sates, some European countries, and Israel. There may be features of sleep in infants and young children that are mostly based on biological tendencies inherent to our species. It is also possible that there may be unique characteristics of some sleep patterns depending on factors such as geographical, socioeconomic, and cultural ones. In adults in the United States, there is some evidence that there may be "ethnic" differences between the sleep patterns of Caucasians and African Americans (Profant et al. 2002).

Naps for Young Children

Parents often question at what age young children "should" not need a nap during the daytime, whether at age 4 or 5 and ask for advice on this point. There are cultures in which children and adults take a nap in the middle of the day (generally called *siesta* in Latin America and Spain), while in other countries adults do not do that, and eventually expect their children to do the same, that is, only sleep during the night. Another example of a connection between sleep patterns and cultural factors is the notion of "a bedtime," which does not exist as such in many social groups, that is, not a time when based on the clock, the children are "put to sleep" (Wortham and Brown 2007). Rather, the moment of going to sleep may depend on light and dark, or on other factors, such as how early activities start the next day and how late the family had dinner. In Spain, for instance, it is commonly seen that families have dinner later at night, and activities even at school start later in the day than would be typical in the United States. In many countries like Spain, Italy, and Latin America children participate in the family's activities in the night, and they may fall asleep where they are, only to later be transported to the bed, so there is no sleep ritual as such.

In the United States, children who attend day care and preschools are "expected" to take a nap or rest for a period of at least one or up to 3 h in the middle of the day. Some children do not need these naps, and they have difficulties with this "quiet time" on which their teachers insist. If they do sleep for 3 h during the day, it would not be surprising if at bedtime they are not sleepy. Their parents may want to have them sleep, for example, around 7 PM, and this tends to create conflicts between parents and children. This is particularly so if the child has spent a long time in preschool and after care and then gets to spend very little time with their parents after their work, around 5:30 to 7 PM. There is scarce scientific information as to the "need" for a nap, when the sleep pattern becomes biphasic (day and night), when the young child does not require a nap, etc. A recent systematic review suggested that naps after 2 years of age tend to delay the time of sleep onset and more disrupted sleep at night, and in general naps are not of much benefit for health in the long term (Thorpe et al. 2015). However, other studies have suggested a benefit in the capacity of the child to learn in preschool settings (Staton et al. 2015).

Where Should the Baby Sleep?

In most of the medical literature on sleeping in infants and young children, it is assumed without question that the "optimal" sleep pattern for a young child is to sleep by him- or herself and to achieve this with minimal intervention from parents (Mosko et al. 1993; Mindell and Owens 2015), despite which parents in the majority of the world's population continue to sleep with their young children for multiple reasons (Nelson et al. 2001). In most cultures in the world, at least mothers and small infants always sleep together.

Fig. 13.1 Sleeping arrangements. (Original artwork by Ana-Marcela Maldonado-Morales)

There is the suggestion that the touch between the two participants produces a feeling of calmness. In Japan, this is referred to as a feeling of *Anshin*, which allows both the baby and the caregiver to go to sleep well (Adis Tahhan 2013; Fukumizu et al. 2005).

In the United States, several northern European countries, New Zealand, and others (Gettler and McKenna 2010), there is presently considerable controversy about what is the "best" or the "safest" strategy for the newborn and infant. The recommendations that professionals and parenting experts provide to new parents are often not presented as that, controversies, but as certainties. In many hospitals, at least in the United States, parents are told that they should never sleep with the baby in the same bed, because of an increased risk of sudden infant death syndrome. This at times is taken to the extreme of being considered as risky behavior close to neglect of medical advice (Ball 2002, 2003, 2009).

In the United States, given the frequently voiced "dangers of co-sleeping," many parents sleep "in secret" with their baby and may not reveal this to their pediatrician. Something similar occurs when immigrant parents from traditional societies are told by well-meaning nurses to "never sleep with the baby," an injunction which they will find strange and counterintuitive, leading them to conceal what they "really do" in their home. Of course, another possibility is that young children may sleep with their siblings, which sometimes they want to do for a feeling of protection. This has been found to be commonly the case in families of minorities in the United States, particularly in African American young children (Milan et al. 2007).

In contrast with this, the UNICEF (United Nations International Children's Emergency Fund) in the United Kingdom recommends as the optimal situation for the baby to sleep with his or her mother on the same bed. This promotes breastfeeding, makes it easier for the mother to care for her baby, and protects against the risk of sudden infant death (McKenna and McDade 2005; UNICEF UK n.d.). What are well-intentioned parents to do? There seems to be a clear association between co-sleeping and a higher odds of breastfeeding and its concomitant benefits (Ball 2003, 2009).

Until a few years ago, the American Academy of Pediatrics' official position regarding newborn and infant sleep was that the newborn should sleep in a separate room from the parents and to be monitored through some electronic device. A few years ago (AAP 2005), this recommendation was changed and now the official advice is that the baby should sleep "in the same room" as the parents, but not on the same bed (Task Force on Sudden Infant Death Syndrome 2011). In many German families, it seems, there is also much emphasis on independence of the infant, to promote this the child is often put to sleep alone (Jenni and O'Connor 2005; Valentin 2005).

Also, until recently the US Consumer Product Safety Commission (US Consumer Product Safety Commission 1999; Drago and Dannenberg 1999) had concluded that the "safest" place for the baby to sleep was inside a crib, which the evidence does not support (Morgan et al. 2006).

On the other hand, parents in most traditional societies and in many industrialized countries practice "co-sleeping" with the baby from birth and certainly later on. It must be mentioned that in many parts of the world houses are not build in

the same way as houses or apartments in industrialized societies and the notion of "privacy" and "rooms" is different. The house may have only one, two, or three "rooms," which are shared by everyone, even to sleep. In many households, the members sleep on the floor, on mats, on straw mats, or they might sleep in hammocks and other similar devices.

Additionally, it must be kept in mind that in many rural environments, undesirable animals, such as rats, mice, scorpions, and others, can "enter the house" and hurt the baby. Parents may prefer to have the baby sleep together with them in order to best protect their child against these dangers. Indeed, in many traditional societies not only the nuclear family, but the extended family sleeps in the same room on the floor or on beds. Among the Maori this was the ancestral custom, and there were meanings associated to the precise sleeping positions of the various family members. This is now disappearing except on ritual celebrations (Van Meijil 2013).

Other "dangers" that may concern parents, particularly likely during the night, may be unwanted or feared "presences" such as ghosts, genies, shadows, and other evil entities that may attempt to kidnap the child, take him or her to the other world, or damage the baby in some way. In rural Ireland, until very recently, Scheper Hughes found that parents still believed that the baby could be "changed" for a different one during the night, and they would have a "changeling" baby instead of their original child. This is more likely when there is something "wrong" with the baby like a malformation or a serious health problem.

A recent survey in Switzerland (Jenni et al. 2005) found that preschool children in a very high proportion spend "part of the night" in the parents' bed, illustrating the tendency of young children to try to sleep together with the parents for many reasons, including emotional needs, common fears, seeking proximity and the like, fears that are very common in the preschool stage. Even in a culture that values independence and self-reliance, parents end up "allowing the children" to spend time in their bed rather than trying to put the child in the middle of the night in their own bed, this probably saves everyone from more sleep deprivation.

As noted before, in many cultures when the child is a little older, or no longer breastfeeding during the night, sometimes because another sibling has been born, the young child will sleep with his or her siblings instead. This has to do with the sheer size of the house, the number of rooms and beds. It is a very common pattern in Latin America, Africa, and many Asian countries (Super and Harkness 2013). Despite the stated parental beliefs regarding sleep, the reality may be that more parents sleep with their young children in the same bed. A recent study (Mindell et al. 2010) compared the sleeping situation in different countries, several from Asia (China, Hong Kong, India, Indonesia, Korea, Japan, Malaysia, Philippines, Singapore, Taiwan, Thailand, and Vietnam) with those of "predominantly Caucasian countries" (United Kingdom, United States, Australia, Canada, and New Zealand) mostly through an Internet-based questionnaire (Brief Infant Sleep Questionnaire). This is obviously based on a parental report (rather than a face-to-face interview or an objective assessment of sleeping arrangements and patterns). The study comprised over 29,000 infants and toddlers in total. The sample also was biased toward parents with electronics availability (having a computer or other device) and more education. In general, parents report a higher frequency of co-sleeping and sleeping in the same room with their infants in Asian countries than in the "Caucasian" ones. The parents from Asian countries also had higher frequencies of difficulties with the infant going to sleep and waking up during the night. Other surveys have shown, even in the United States that up to 50% of mothers sleep with their baby in the same bed at least part of the night (McKenna and McDade 2005). A study in Japan, contrary to the findings in the previously cited study (Latz et al. 1999), showed that parents rarely complained of sleep problems in their young child, which in the United States is very frequent. In Japan, traditionally parents and children sleep together on futons in the same room, the parents on both edges, and the children in the middle, even throughout childhood and adolescence. Japanese parents do not seem so intent on promoting independence during sleep.

In many cultures, sleeping together with the baby is only one further expression of "sleeping together with others" that is a common practice. The notion of sleeping "all alone" is strange, as closeness and emotion are expressed through the body, even during sleep. Who sleeps next to whom in large sleeping rooms with multiple people demonstrates feelings of tenderness, friendship, protectiveness, while anger and sadness may be represented by

sleeping farther away (Musharbash 2013). The notion of "sleeping privately" is not important and is counterintuitive, as people would "naturally" not want to sleep alone.

Swaddling

This is an ancient practice in many cultures. It consists of wrapping the infant so that he or she can move very little, and then sleep better and cry less. It has been practiced traditionally in Native American cultures, as well as in many Asian societies, Russia, the Middle East, and Latin America. It is often used also in the United States and Canada. The available information from studies permits to conclude that it is an overall safe practice, that it leads to more continued sleep in the baby at least in the perception of mothers and from physiological studies (Richardson et al. 2010), and to experiencing less pain during procedures (Van Sleuwen et al. 2007). It is thought that it may give the baby a feeling of contentment and calm. One of the concerns about swaddling is how long should it be implemented. It is recommended only for the first few months of life, as later on the baby tends to roll over and may feel constrained or may be unable to move his or her arms if he were to end up "face down."

Sleeping in Hammock

In many cultural groups, adults and children sleep in hammocks. It is common that a woman who just had a baby may sleep in the same hammock with the newborn, who when older, may sleep in his own small hammock. The mother may sing to the baby and rock him, providing auditory and vestibular "entraining" stimulation that may promote sleep onset (Valbuena Sarmiento 2004). Hammocks are used in Latin America, South East Asia, and Africa. In the neonatal intensive care units in some countries like Sweden, premature babies spend part of the time in a hammock, as this provides soothing movement and containment that simulates to a degree the position in the womb.

Issues and Meanings of Sleep Onset

When and how should young children go to sleep? The sleeping situation.

In many traditional and modern cultures, the sleep onset of the young child is an opportunity for an intimate moment of sharing, time, interactions, perhaps songs and stories. In contrast, in many families the child is "sent to sleep" or put to bed and he or she is hoped to go to sleep on his or her own, or with minimal intervention from the parents, in order to promote putting oneself to sleep.

Even in the case of small infants, several experts in the Western world recommend that parents should never "allow" the baby to sleep in one's arms while rocking. It is preferred that as the child is "almost sleep," he or she be put on the crib, and if the child cries a little, the baby should soothe himself with little intervention and thus go to sleep through self-soothing techniques. The same recommendation is made for older infants and preschool children, some authors even advice to put a "barrier" in the door of the child's room so he or she cannot get out, a maneuver called "setting limits."

Berceuses or Lullabies and Storytelling

Parents from many cultures around the world, for many generations used the sleep time as an opportunity for interpersonal exchanges, and the shared experiences included singing of songs to promote sleep (Parrat-Dayan 1991) and storytelling. There are *berceuses* (lullabies) in many cultures, and many mothers and fathers still practice this (Altmann de Litvan 2012). A recent small survey in Germany indicated that 95% of mothers sing lullabies to their babies (Valentin 2005). In Uruguay, some researches explored whether when the mother or a caregiver sings lullabies, there is a more secure attachment toward caregiver, denoting increased sensitivity in the adult toward the emotional needs of the child. This practice is quickly being lost in many industrialized countries and could be replaced by devices

that sing songs mechanically (Valbuena Sarmiento 2004), or by nothing except perhaps some transitional objects.

Traditionally lullabies were songs that were sung by the caregiver, mother, grandmother, or father to induce the baby to sleep. It is usually a psycho-corporal experience in the sense that there is the musical-auditory component, as well as the attention to the baby and the rhythmic movement or rocking so that the child will relax and fall asleep. Certainly, many lullabies are a mixture of praise and loving declarations, mixed with threats (throwing to the wolves, hitting, falling down) if the child does not go to sleep, a fact pointed out by Winnicott (1949) decades ago. In a small rural village in Iran, a researcher analyzed the *berceuses*, which were accompanied by "youncing," a sort of rocking mixed with being thrown a little in the air, a few inches and caught which is expected to help the baby go to sleep more easily (Friedl 1997).

Also under threat of disappearance, parents in many industrialized countries "read books" to their young children at bedtime. At times, the child insists on one book after another. Storytelling is a strategy that was passed from generation to generation and is still practiced in many parts of the world, among other things, because there may be little access to "children's books." The storytelling of the same stories night after night, in a soft voice and monotonous way as the story progresses in detail (Hill 2011), may induce a hypnotic or relaxed state in the child that may facilitate sleep onset (Lenox 2000).

Insomnia

Difficulties going to sleep: Describing sleep problems as a purely "physiological" or brain problem does not take into account the interpersonal and cultural nature of sleep. For example, parents in Italy, in many Asian and Latin American countries might think it is inappropriate to have a young child sleep in a separate room (Jenni and Werner 2011). This issue is important as many young children want to sleep with their parents and report various fears when one insists they sleep in a darkened room or with the door closed.

One of the most common sleep difficulties in young children is precisely the difficulty to fall asleep, which are identified in around 15–20% of children in the United States and Canadian samples of young children (Calhoun et al. 2014; Petit et al. 2007). Although on surface this appears as a purely "biological problem," often it is not so, but a mixture of the predispositions of the individual child in interaction with parental practices and expectations. In several industrialized countries like France (Parrat-Dayan 1991) and the United States (Zito et al. 2000) in the past few decades there has been an enormous increase in the demand for medications and prescriptions to induce sleep in young children, given the perceived difficulty to get them to go to sleep. There are also a number of sleep aides that are sold in stores without prescription, like anti-histaminic and melatonin that are widely used by parents to get their young children to sleep.

The foster mother of a 3-year-old boy called asking for an immediate intervention with her foster son. She discussed the issue with the child psychiatrist. She was alarmed that the foster child had enormous difficulties to go to sleep and it had taken about 2 h for him to go to sleep last night. When the child psychiatrist asked for more details, it turned out that this had been the first night that this little boy had been placed with her and he had been removed from his mother's home during the day. The foster mother had sent the child to bed "in his own room" and the boy kept coming out of it with multiple "pretexts" such as being thirsty, going to the bathroom, being hungry, and being scared. The foster mother requested a pharmacological treatment to put the child to sleep that next night. The psychiatrist suggested to her that it would be very normal and expectable for a young child to have difficulty to go to sleep in a stranger's home, as probably he missed his mother, other relatives, and his home. The foster mother was frustrated and puzzled, as she saw the sleep as a purely physiological phenomenon, and thought the child "should be tired" and just go to sleep like her other foster children.

This vignette is used to illustrate the cultural expectations for a very young child, who has experienced a lot of stress while living with his mother, and now without her. It also illustrates the transactional nature of "going to sleep" and the fact that it is not merely a biological phenomenon, but one which is influenced strongly by culture, relationships, and the need to feel safe and secure before going to sleep. Incidentally, in the United States, foster parents are not allowed to sleep with children, even very young ones, in the same bed, as specified by the child protection agencies, for fear of misinterpretations about sexual abuse.

There is evidence that emotional difficulties in the mother have a negative impact on the sleep of the infant, such as intense anxiety, traumatic events, tension and discord in the family, an insecure attachment, and mother–infant separation (Sadeh 1996).

The above is obviously related to the life experience of the family. In many places in the world, there is great insecurity, such as in "war zones," there are millions of displaced families, parents who live in constant stress, in conditions of poverty and high crime areas, or who have undergone many traumatic events themselves during childhood. It also appears that the more the mother worries about the baby's fears and worries during the night, the more disrupted the sleep in the baby tends to be (Tikotzky and Sadeh 2009). It is also clear that the characteristics and sleep issues in the child have an impact on the perceptions of the parents regarding infant sleep, that is, a bidirectional effect. It scarcely needs to be mentioned that in most cultures in the world people believe in evil beings that are lurking around, such as evil spirits, witches, demons, ghosts, etc. When young children hear these stories, which often the parents endorse in reality, the children would be afraid to sleep alone.

The notion that a preschool age child may struggle to go to sleep and that he or she may want proximity with the parent is a very obvious one in some cultures, but a less accepted one in other cultures. It seems that an essential condition to fall asleep is to feel safe and not to be scared, which may be hard for some preschool age children.

Sleeping patterns that have been in existence for centuries, may give way to a more "scientific" pattern of putting the child to sleep based on the advice of medical or psychological experts. For instance, even the International Association for Sleep Medicine contemplates a category of sleep disorder called "limit setting sleep disorder" (American Academy of Sleep Disorders 2006). This indicates the notion that parents should enforce, insist, and not relent in their expectation that a young child stay in his or her room, on the bed, or in the room at all costs, and failure to do that constitutes a transactional problem of "difficulty to set limits" (Mindell and Owens 2015). We frequently have the experience that a child who is particularly anxious, temperamentally cautious, or who has experienced a troubling event may seek to sleep with the parent at least temporarily, and the caregivers are caught between their intuitive need to comfort their child and the advice from experts who warn against the dangers of this practice of "giving in" (Sadeh et al. 2010). The cultural basis for this transactional difficulty is made even more obvious when one thinks of many homes in the world in which children do not have "their own room" but always sleep accompanied by adults (Rowe 2003).

Parents might be surprised at the advice of medical or sleep disorder experts who recommend strategies such as "shutting the door" to prevent the young child from leaving the room or coming out of it. The same can be said about the use of "gates" so that the child stays behind that very gate or even a "cover" over a crib to prevent the toddler from climbing out of it. Many parents in every culture would find these recommendations rather insensitive or scary to the child. On the other hand, it must be added that many of the parents who hear the advice from experts desperately need to sleep themselves, as they have to work the next day and need a "radical solution" to the problem of the child seeking proximity. This demand may be one of the drives to seek a rapid cure for the problem, including the use of medications, even for quite young children. One can see that the lifestyle of the parents, the need for sleep, and

the demands of their schedule dictate the search for a solution to a difficult problem, which may be that the child wants to spend as much time with his or her parents.

Difficulties staying asleep: There is also controversy as to what parents "should" do when the baby wakes up and cries during the night. The sleep physiology of young children determines that every young child would wake up briefly about every 90 min or so and then go back to sleep. In many cultures, as the parents sleep with the baby this may not be a question. In some countries, like the United States and some North European ones, parents hear the advice that the baby should sleep separately. Another recommendation is that during the night, they should not pick the infant up; rather, after ensuring the child is safe, they should let the baby "cry it out" until he falls asleep. Parents worry if they are doing the correct thing. This used to be the uniform advice from pediatricians to parents 20 years ago (Ferber 2008). Nowadays there are other approaches that parents may find more acceptable, such as intervention to soothe the baby during the night and gradual extinction (Minde 2002). Another method is using a sleep aid such as an item of clothing with the odor of the mother or father during the night (Goodlin-Jones et al. 1997). A further idea is to reflect or think about what might be the baby's emotional state, imagine being the child, and think of how to reassure the baby and how to deal with his distress. The point here would be to help the child feel less distressed and safe, rather than just getting him or her to be quiet and fall asleep, or be resigned that nobody will be there to assist the infant.

Immigrant parents and parents who have had losses and trauma in the past may find it difficult to follow advice geared toward ignoring the baby's cries at night because they fear that something bad might happen to the child. Also, many babies cry very intensely, and they may start coughing, vomiting, or be inconsolable for a long period of time. This makes it impossible to follow those recommendations.

Snoring in Young Children

Snoring results from the forced passage of air through the upper airways during sleep, which may or may not lead to episodes of obstructive apnea. There are cultural variations in the meaning of snoring. In the industrialized Western world, it may be either ignored, overlooked, or thought to be a problem to be further investigated as "not normal." It has been reported that in China, snoring can be celebrated by parents as a sign that their child is very strong "like a man" (Owens 2005). One often finds "hyperactive" or irritable children who are sleeping poorly due to obstructive sleep apnea, which affects around 3–4% of young children (Lumeng and Chervin 2008).

Parasomnias

Parasomnias are sleep abnormalities that occur during non-REM sleep, that is, during the deep states of sleep. They are considered a "problem of arousal" to speak because manifestations that normally do not take place during sleep occur during parasomnias. These include sleepwalking (somnambulism), sleep terrors or *pavor nocturnus* (in which the child speaks, appears frightened, but is not really awake), and confusional awakenings (the child wakes up but not fully, he or she is still partially asleep) (Kotagal 2009). In the toddler that hardly walks, sleepwalking may manifest by crawling and moving around the crib. All the parasomnias are quite frequent in young children and tend to diminish in frequency with age. It is understandable that a number of "explanations" would be proposed in different cultural groups for the occurrence of these problems and for their solution. As noted, in many cultures the spirit of the person is thought to have a "life of its own" and the surround spirits do also, being able to attack and frighten vulnerable people, that is, young children. One frequent association in many traditional cultures is between sleepwalking and a state of trance. Parasomnias are thought to occur more frequently

in children under intense stress, so it is possible that preschool children and infants exposed to difficult circumstances, including separation anxiety, and sleep deprivation would have more sleep difficulties in general, and parasomnias in particular (Kotagal 2009, 2012).

Other parasomnias are associated with REM sleep, like frequent nightmares. Catathrenia, or groaning during sleep, occurs during both REM and non-REM sleep. Bruxism, or teeth grinding, is considered as a movement disorder related to sleep.

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Culture and Eating in the Perinatal Period and Early Childhood

14

J. Martin Maldonado-Duran, Teresa Lartigue Becerra, and Kenia Gomez

Fig. 14.1 Breastfeeding. (Original artwork by Ana-Marcela Maldonado-Morales)

The Ethological Dimensions of Feeding/Eating

It is clear that among the primary animal functions, adults eating and feeding the young are extremely important for survival individually and of the species. In many species of the animal world, access to food and water is a primary reason to maintain a certain territory, and together with sleep, it is absolutely essential.

Eating is therefore, aside a cultural phenomenon, an "animal behavior." Among humans, breastfeeding by the mother or "wet nurses" (which can be unrelated females or aunts) is a practice that favors the survival of the young, as well as keeping the infants close and protected by adults. Incidentally in the past, medical treatises discouraged using wet nurses because it was thought that the psychological traits of the wet nurse were also transmitted to the sucking infant, besides the milk (Stevens et al. 2009). Primates, and particularly humans, in comparison to other mammals have very diluted milk. Therefore, infants have to be breastfed quite frequently. Other mammals, with richer milk per volume, may feed the baby only once or twice a day very "thick" milk and keep the babies concealed in a den while the adults go to feed themselves through gathering food or hunting.

Human babies are highly "altricial" (like birds) in the sense that they are highly dependent on others to survive, as they are motorically quite immature and cannot fend for themselves. Feeding an infant is a very "high cost" activity for a primate or human mother, which means that

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much time has to be devoted to that and the baby depends totally on the mother. Fathers tend to serve a supporting role at this initial stage, mostly to feed the new mother and to protect her.

The normal human newborn will triplicate its weight in 1 year, needing constant feeding for this, particularly to support the development of the brain, which requires a lot of lipids and proteins, and of course also to support the rest of the body. This means a lot of sacrifices for adults during at least that first year of life, and often much longer. Many mothers will find themselves somewhat overwhelmed by the enormous needs of the baby, the crying that signals hunger and the need to be soothed frequently.

Different cultures around the world promote diverse practices to favor the well-being or survival of the mother and baby during this critical period. These practices have an adaptive value and may seem strange to a very Westernized clinician who might think of feeding infants as a very easy thing, a matter of "just" breastfeeding or mixing formula, warming it and giving it to the baby when required.

Cultural Representations: The Meaning of Food and Eating

With a human history plagued with continuous or episodic scarcity, famine, poverty, or difficulty to access food, it is not surprising that in many cultures food is something very central to all relationships, almost sacred, something to be cherished and shared with the family. The love of the parents, particularly the mother (traditionally), might be shown by the preparation of the food. The meal assumes a representation of the warmth and love of the caregivers, with its diverse flavors, smells, textures, etc. Prepared food is invested with considerable symbolic meaning, beyond the pure protein, carbohydrate, or caloric properties. In many traditional societies, preparing of food, the specific features of their cuisine, and the mealtime have a social meaning and symbolic value. Typically, in traditional societies most celebrations are marked by special food, which assumes an enormous importance as a manifestation of affection, happiness, and well-being. This might be less obvious in the more rushed everyday life in industrialized societies, but it may remain true particularly for celebrations and to mark special events.

In many cultures, the food is consumed at times as a ritualized experience, with certain symbolic acts that represent something else than the food itself. If one considers the meal of the Passover (*Pessach*) in many Jewish families, it includes eating certain dishes, which may remind of the past experiences of ancestors, that is, the Exodus, and includes seven traditional foods, each with a symbolic value: *matza* or unleavened bread to symbolize the hurried departure from Egypt, and bitter herbs (*maror*) to symbolize the bitterness of the period of their slavery, to name just a few. Other cultures have similar rituals to remind them of important events or to convey a meaning.

People as children develop a strong attachment to "their foods" and this is a particular salient issue for displaced families, such as immigrants, who may miss their food intensely or claim that "the ingredients do not taste the same" in their adopted country. Due to this dynamic, many recent immigrants report that they find the local food insipid or bland, or the ingredients are not what they expected, etc. In many traditional cultures (in Asia, Africa, and Latin America), insects are consumed regularly, a practice that many in the Western world would find abhorrent (Chakravorty et al. 2011). However, ants and crickets are cooked regularly. The same could be said of worms.

Food and its consumption also vary in two important dimensions: the variety of food and the frequency of eating. In many social groups, people may eat the same foods everyday and not expect great variety in the food consumed, which is the norm in the industrialized world. People might eat rice everyday, potatoes, corn, tortillas, beans, yams, as this is the available and staple food to feel like eating different kinds of food on a daily basis. They may not expect to have a variety as people do in other countries. The issue of the frequency of meals is that in many cultures people "do not eat all the time" the way people

tend to do in the West. People may eat one or two meals per day and they do not expect having "snacks" and drinks throughout the day. A relatively recent phenomenon in the wealthier countries is the movement toward less "artificial foods," that is, those who can afford it attempt to eat organic food, not genetically modified, without artificial flavors and colors, etc. Many are trying to limit or eliminate gluten for health reasons. In many cultural traditions certain foods are associated with medicinal or curative properties at various stages of life, or for particular ailments.

Cultural Identity Through Regional Cuisine

There are some popular cuisines, such as the French, Italian, Mexican, Chinese, Indian, etc., and restaurants of these styles are flourishing in much of the Western world. Countries and ethnic groups generally are very proud of their cuisine and may think it is "the best." People from a given social group have an attachment to the traditional dishes, which may represent for them the earliest manifestation of maternal love or belonging to a family. Many immigrants long for the "real food" of their home country. This issue of what to eat and how to cook it, how it should be flavored, cut, cooked, and presented clearly involves ancestral influences. This also has an impact of what an infant and young child will learn to eat or will consider as edible or even a delicacy.

Food Taboos

The prohibition and avoidance of certain foods exist in all cultures, which have clear rules about what foods are unacceptable. At the same time, what is forbidden for one group is a favored food for another. Food taboos may have multiple origins, including ecological ones, the difficulties in keeping certain foods from spoiling, their availability, or their suspected properties or effects on humans. It is necessary to recognize their nature in order to understand why a woman who is expecting a baby or is breastfeeding may not eat certain foods, or she would never give them to her toddler or young child.

One of the most widespread taboos is against eating meat altogether. This is a traditional practice in several parts of India, for religious reasons, families for multiple generations do not eat meat and raise their babies without it. For different reasons, in the Western world there are now many families that are vegetarian, either for health concerns or because of the wish to preserve the environment. Young children who are fed exclusively a vegetarian diet may need to be monitored for the absence of certain vitamins and microelements.

Another major dietary taboo due to religious reasons among Muslims and in the Jewish tradition is the prohibition to eat pork. Also, any meat that is consumed, in the observant families, has to be *halal* or *kosher*, that is, its preparation according to rituals in which the meat is kept separate from other foods, like milk products, the cooking utensils also have to be kept aside, and the animal that is sacrificed and whose meat is consumed has to be bled in a ritualized way so as to minimize the consumption of blood.

In many traditional societies, there are further food taboos that are only specific for certain stages of life, for instance, during pregnancy or for a lactating mother, during menstruation, etc. (Meyer-Rochow 2009; Santos-Torres and Vásquez-Garibay 2003). The dichotomies dry–wet, cooked–raw, hot–cold, vegetable–animal, liquid–solid are part of the "classifications" usually unwritten, of foods that are acceptable in different cultural groups, at various times of life. Among some tribal groups in Malaysia (Meyer-Rochow 2009), animals flesh can be eaten, but only when one attains a certain age. An infant can eat animal proteins, but only of very small animals, such as birds, fish, and mice. The reason is that all animals have spirits and the spirit of the animal competes with the spirit of the human consuming its flesh, and the young child could not compete with the spirits of large animals, which are only permissible to eat after about 20 years of age. Although this may sound out-

landish, all cultures have classifications based on multiple factors to determine what is forbidden or prescribed. Taboos can also be temporary, as it is observed in the care of many infants and young children. If the child is sick, has a cough or diarrhea, some foods are not permitted and others used as remedy.

In many cultures pregnant women are expected to observe particular taboos, which are too numerous to mention. There is the taboo against eating "cold foods" in a hot state such as pregnancy, although some "not too cold" foods may be permitted to balance the hotness of the pregnancy, as in Mexico (Mennella et al. 2005), and eating hot peppers (*chiles*) should be avoided because they are too hot. Other prohibitions include animals like snakes, snails, and worms, which are considered poisonous or unclean particularly in pregnancy. There are number of "forbidden fruits" in several cultures that are thought to lead to malformations or to a miscarriage, as they may weaken the womb or damage the baby. Other foods that are often "suspicious" are fish and seafood, in general. Some foods are thought to actually induce miscarriages (e.g., *paw paw* = *Carica papaya* and jackfruit in some areas of India), while other foods consumed during pregnancy are thought to affect the developing fetus in a negative way, fruits and sweets being common items forbidden in various cultures (Lee et al. 2009).

Even though in India castes are officially not recognized, people still adhere partially to the classification into four main castes, the highest one being the Brahmin (priestly caste). Traditionally, a Brahmin woman has to be extremely careful with her diet and must perform a laborious purification of the body in case of contamination. She cannot eat any meat, fish, and in the most orthopraxic groups, should never cook these (Harper 1964). All consumed food should be "pure" and even the act of eating is considered polluting due to the impurity of saliva.

Regarding the period of lactation, in most cultures, there is advice as to foods to be avoided or preferentially consumed. In areas of China and Southeast Asia, delivering a baby is thought to leave the body "cold" and hot foods are recommended. In areas of Brazil, women should not mix eating milk products with fruit or meat with fruit (Trigo et al. 1989). In Mexico, in many areas, cold foods are avoided, which include some fruits that can "make the milk go away" (Santos-Torres and Vásquez-Garibay 2003). Conversely, various herbal remedies, beer without alcohol, oatmeal, and other foods are recommended to favor milk production.

The dietary taboos can have negative consequences for the quality of the breast milk. In Vientiane, the capital of Laos, it was found that some babies developed *beriberi*, a severe cardiac illness as a result of vitamin B2 deficiency, which was related to exclusive consumption of rice during lactation by the mother, leaving it to cook for very long periods of time, and avoiding meats (Soukaloun et al. 2003). In some areas of Malaysia, meat is strongly discouraged, as it is "too strong," so a significant proportion of women are undernourished and this may lead to a poor nutritional quality of the breast milk. In Cambodia, it is traditional for women to have vapor baths as well as to drink infusions of herbs and wine (*tnam sra*) to favor the production of milk, and to eat mostly soups. Elders recommend eating foods with ginger and pepper after the birth of the baby for the recovery of the mother (Straub et al. 2008).

A number of taboos are also observed across the world for infants and young children. Traditionally, in some parts of Nigeria, young children are not given meat or eggs, as it is thought it will make them steal as they grow up (Meyer-Rochow 2009), nor and coconut milk which could make them less intelligent. Foods that the young child consumes in general can be associated with future character traits (Odebiyi 1989).

The Nutrition of the Expectant Mother

As a special and "more vulnerable" stage of life in women, most cultures have prescriptions and prohibitions as to what a future mother should eat, in order to ensure the optimal outcome for

her and the baby. In the West, it used to be advised by grandmothers and other women that the future mother should "eat for two" so that the baby had an adequate growth in utero. In the last century, the pregnancy itself has become increasingly "medicalized" and women are expected to see a physician or specialized nurse multiple times in the course of the pregnancy and her weight gain is carefully monitored, in terms of its excess or deficit. Vitamins, such as folic acid, and micronutrients and iron may be recommended depending on laboratory studies and the need to prevent neural tube malformations. Women worry about eating foods which might contain mercury and diets are designed to control a tendency to develop gestational diabetes in women who are at risk. These subjects have become common place in industrialized countries when women have access to health care, which is guaranteed in many European countries, Canada, and Australia. This is not the case in all industrialized countries, like in the United States. In the United States, many women who live in poverty as well as immigrant or undocumented women have more barriers to access health care and may do so only temporarily or in a restricted fashion (like only 6 weeks after the delivery).

For many centuries, pregnancies were considered simply as "something natural," albeit dangerous, and the woman was assisted by her family (mostly women), religious figures, healers, and a number of interventions to prevent a negative outcome. Maternal death was a very realistic risk for women, who could die during the delivery or in the postpartum stage from hemorrhages, infections, and other multiple complications. Perinatal mortality is still very much a real possibility for women in many regions of the world given difficulties with nutrition, hygiene, access to care, and other services (World Health Organization et al. 2010), and it is the highest in several African Countries, some in Southeast Asia, and Latin America. Many of these conditions would be preventable if there were more access to care, monitoring, and interventions. The global maternity death rate was 216 deaths per 100,000 deliveries (Alkema et al. 2016) in 2015. To give a brief idea of the differences per regions, the death rate in high-income countries is around 12 deaths per 100,000 deliveries versus 446 deaths per 100,000 deliveries in countries of Sub-Saharan Africa.

All this is mentioned to consider the importance of eating and nutrition as one of the aspects that is—theoretically at least—under the control of the pregnant woman and her relatives or healing agents to favor a healthy process and outcome.

Malnutrition During Pregnancy

In many nonindustrialized countries, women do not have access to enough food for themselves, even during pregnancy, due to poverty, and the problem will be not gaining enough weight during the pregnancy and having a baby with intrauterine growth retardation. This is generally considered as an infant that weighs <2.5 kg if he or she is at term (approximately 5 pounds). This has been correlated with negative health outcomes later on in life, during the adult life of the son or daughter. The phenomenon has been called the "programming hypothesis" (Barker 2000; De Boo and Harding 2006). The long-term negative outcomes have been called globally the "X syndrome," which includes obesity, high waist circumference, higher risk of developing arterial hypertension, developing cardiac disease, having a cerebrovascular accident, and even depression. This has been shown in various scenarios in which pregnant women were exposed to famine, for instance, in Holland, during the Nazi occupation, in which some villages were "punished" by the Nazi army with blockades of food, due to their cooperation with the enemy. Also, the phenomenon occurred in China during the periods of famines and in Scotland in some areas also during World War II. The babies had low birthweight, and then as they became adults, a higher risk of developing the X syndrome (Prentice and Moore 2005).

In less extreme situations, as it occurs currently in many poor countries, a woman can be malnourished already and then become pregnant. A "competition" is established between the mother and the baby in utero for nutrients that

both need. The baby tends to have low birthweight simply because his or her mother does not eat enough food. Clinicians distinguish two types of fetal malnutrition, symmetrical and asymmetrical. The worse is the symmetrical malnutrition. The "symmetry" refers to the proportion in size between the head of the baby and the rest of the body. If the baby is generally small, including the head ("symmetrical"), this is thought to have a worse outcome in terms of cognition and brain development, as the head is also small. In the asymmetrical growth deficit, the head is relatively larger in proportion to the rest of the body, suggesting that the brain was relatively spared. This has a better outcome and the malnutrition occurred later in the pregnancy, giving time for the head and brain to grow larger with respect to the rest of the body (Longo et al. 2013).

Unfortunately, child malnutrition, adult malnutrition, and growth stunting (the baby does not grow as expected in height after birth) are still highly prevalent in many poor regions in the world, like Mexico, Central America, some in South America, Africa, Asia (India, Pakistan, and many others), and immigrant, undocumented, and very poor families in the "developed world." These phenomena can occur even if the baby was not born small for gestational age. Indeed, one of the risks for babies in those areas occurs once the mother stops breastfeeding her child. Breastfeeding ensures generally an adequate growth, but after weaning, the growth curve of the baby starts declining due to the poor nutrition the child will receive, like the rest of the members of the family (Marquis et al. 1997). Also, as the infant is not breastfed anymore, the risk of diarrhea due to infections and food preparation increases (Brown et al. 1989), this is a tendency that has been observed in many countries. The introduction of other foods than breast milk and weaning, termination of breastfeeding, are highly controversial and vary a lot between cultures. In countries with a great deal of poverty, the consequences of weaning early may be disastrous for the child. Many mothers who experience adverse situations interrupt the breastfeeding due to various circumstances, including the need to work, multiple demands on the woman, and stress. In Haiti, a condition known as *let gaté* denotes a "ruined milk" when the mother is experiencing much distress or is scared and feeds the baby, who in turn will "become sick" (Farmer 1988).

Obesity and Pregnancy

The opposite issue is plaguing wealthier countries, i.e., obesity during pregnancy. About a third of adult women in the United States are obese, and obstetricians warn against complications like gestational diabetes, preeclampsia, perinatal complications, and health difficulties in the baby (American College of Obstetricians and Gynecologists 2005; Smith et al. 2008). This does not mean that obesity is only observed in rich countries, as in low-income countries, there is also a high rate of obesity due to the quality of the food available, this is observed in Mexico, and it is also true in the United States among sectors who live in poverty (Monteiro et al. 2004). Obesity, of course, does not only have to do with ingestion of calories and quality of foods, but also with level of physical activity and lifestyle changes in urban areas in developed and poor countries (Popkin 2001). Indeed, some families have undernourished and obese members. Also an increasing phenomenon, predominantly in highly industrialized countries, is the fear of many future mothers to gain weight during pregnancy and the coexistence of this with eating disorders (Micali et al. 2007).

Cravings and Food Aversions During Pregnancy

Food cravings and aversions are quite frequent, it appears that around 70% of women experience food cravings sometime in any given year (Pelchat 1997), and a similar proportion manifest food aversions, which is different from culturally prescribed food taboos. Aversion to bitter foods might have an adaptive value, because of possible poisoning or intoxications. Food cravings during pregnancy in the West are considered normative and "universal." Indeed, they appear to be quite

frequent, as between 50% and 90% of women experience them (Pope et al. 1992). The most frequent craved foods are sweets and chocolate. In addition to just pregnancy, intense cravings are associated with obesity, gestational diabetes, and with depression and feelings of guilt (Belzer et al. 2010). In those situations, the food is eaten to assuage those emotional states. There is little information about this phenomenon in other cultures. It is clear also that the amniotic fluid and breast milk are "flavored" by what the mother eats, at least to some extent (Mennella 2009), and this might be the earliest for exposure to different flavors while the baby is still in utero.

Pica During Pregnancy

In addition to the "usual cravings" of women, pica can occur with high frequency during pregnancy. Pica is the act of eating normally "nonedible" items, which of course varies with different cultural groups. The items go from ice and frozen items, to dirt, clay, ashes, cigarette butts, paper, charcoal, pieces of burnt matches, hair, and coffee grounds, among many others. It seems to occur everywhere with different manifestations, and worldwide the prevalence is of around 20% (Fawcett et al. 2016).

Pica is observed in African American women in the United States, with a much higher frequency than in Caucasian women, and in the world the highest rates are in African women. This includes pagophagia (craving to eat ice) (Parry-Jones 1992) and a desire for chalk, for powdered starch or dirt. In Mexican women, pica has been found frequently among low-income women, a study found a prevalence of around 35% (Simpson et al. 2000). In studies in Iranian women, around 25% (Ezzeddin et al. 2015) manifested pica. The most common ingested items were dirt, clay, and starch, among others. In Nigerian expecting women eating clay seems almost normative, as a majority of women seem to do it at least to a degree, which has been found to contain kaolinite, which helps women against diarrhea and may protect the mucosa against irritation. Many women are convinced that it has protective value and helps to protect the baby in utero against poisonous substances (Nwafor 2008).

The Care of the Breastfeeding Mother

There are a number of recommendations and "proscriptions" as to what the mother should do to promote an optimal breastfeeding, producing the best or the most milk, and to maintain her health during this stage. Many women are discouraged to eat foods that could cause "gas" or colic to the baby, such as cabbage or chocolate. In some parts of Mexico and in many other cultures, there are proscriptions about "eating cold foods" that might interrupt the flow of milk. The belief about what products are hot or cold depends on the group and it may not have much to do with the actual temperature of the food.

Another salient dimension of breastfeeding in many traditional societies is its effect in preventing another pregnancy, promoting the spacing of children, which is a widely held belief and has a physiological basis (Tommaselli et al. 2000); it may constitute the only acceptable method of birth control (Ertem 2011). Therefore, breastfeeding may have the advantage to give time for the youngest baby to thrive and for the mother to recuperate.

Feeding Young Children

For the most part, mothers and other primary caregivers see as their primary function to feed their son or daughter and promote their growth. When this function fails, it causes much distress to all caregivers. Increasingly fathers are participating in feeding their infants and young children at least in the more industrialized countries, not so much in traditional cultures (Buskens et al. 2007).

For many centuries, infant feeding was merely a matter of tradition. Habits and "ways of doing it" that were transmitted from one generation to the next without much interference from any-

body. In the past, people from higher classes could hire "wet nurses" to breastfeed their babies because they could not or did not want to do it. For the majority of people, breastfeeding was the only way of a mother feeding her child for periods of months or years. Only in the twentieth century, the feeding and other aspects of the care of babies became a "scientific matter" and then a medical one. In the most industrialized societies, the mother takes the baby to the pediatrician for regular check-ups, and the physician is expected to impart advice on the best methods of feeding the baby based on scientific principles, nutritional needs, measurements of weight and height, and the outlook for the future. Feeding in these societies has become the province of pediatricians and doctors in general (Apple 1987).

Breastfeeding Versus Milk Formulas

In many cultures, the newborn is not breastfed for the first few days (Pak-Gorstein et al. 2009; Rogers et al. 2011) for several reasons. The colostrum is considered not nutritious or even bad for the infant, it can be considered as "old milk" or as "polluted substance." Also, in some groups, it was considered necessary to wait until all the meconium were eliminated, which was promoted with a variety of options such as "*ghuttis*," water, water with honey, or "*atoles*" (a concoction made with maize) among the Mayans even at present. In Peru, the practice of "*paladeo*" (tasting with the palate) was giving the newborn a syrup made with chicory or endive before introducing breast milk (Radbill 1981). In Southern Turkey, water with sugar is used as an alternative to colostrum (Saka et al. 2005).

In many societies, mothers prefer to have boys, or having a boy gives more social prestige (Graham et al. 1998). Also, this is often related to having to "eat more" or better foods if the mother had a boy compared with a girl as boys "may need more nutrients" or of better quality. As a result, boys are often introduced to supplementary foods in addition to the breast milk earlier than girls. In some parts of Africa, mothers consider that since milk is liquid, it is not "really" a nutrient and introduce solids relatively early.

The rates of breastfeeding by mothers are a major issue of concern for health systems, and for societies as a whole. Prior to the twentieth century, it was the most used method to feed infants, except for very unusual cases. In the beginning of the twentieth century, professionals in the medical field in the Westernized world appropriated this function and made recommendations for women to feed formula with a bottle so "they would know exactly how much the baby ate" and because it was less animalistic and primitive. The bottles were to be given exactly at certain time intervals (Fomon 2001). Gradually, this recommendation has been changing and now it is universally accepted that "breastfeeding is the best" even if in many centers still it is not encouraged actively, by hospital authorities or even by the governments.

Breastfeeding is not only an individual choice of a woman or of a couple, there are multiple barriers. One is economic, as many women who are poor or live in a poor country are forced to work outside the home, often far from their home, and this makes breastfeeding particularly difficult. Another barrier is cultural; in the United States, there is a clear concern that some groups are breastfeeding less or with lower frequency, for instance, Afro-American new mothers of low socioeconomical status. Mothers often have to work outside the home and place the baby in a childcare center or leave the infant with relatives.

The question is not just whether breastfeeding is initiated, but how long it is maintained. Although the World Health Organization recommends at least 1 year, this is often not practiced. In Nordic European countries, the persistence is higher than in many other areas. In Latin America, mothers who live in rural areas are more likely to breastfeed, and they also tend to be more at home. Nevertheless, the rates of breastfeeding are increasing perhaps due to programs from governments which encourage breastfeeding as the "best method" and because of "baby-friendly hospitals," in which formulas are not introduced by the hospital staff and mothers are encouraged

to stay with the baby continuously. Breastfeeding rates are increasing in Latin America (Perez-Escamilla 2001), and they are very high in many traditional cultures. Often if a mother does not produce enough milk or is sick, a relative or a friend can breastfeed the baby and he or she is considered a “milk-brother” or “milk-sister” of the biological children of the woman who breastfed such an infant.

In many cultures, there is the belief that the emotional state of the mother has an influence on the “quality” of the milk and even on the quantity. If the woman who feeds her baby at the breast has a strong fright, it is thought that the milk production can be interrupted (Pak-Gorstein et al. 2009). In Bolivia, a culture-bound condition known as *arrebato* (sudden impression) is attributed to a mother experiencing an intense fright, a negative experience, or feeling enraged due to life events: feeding the baby in those states could “make the baby sick,” and it is feared that the baby might develop vomiting, diarrhea, and that the milk would be bad for him or her in general. This may lead to sudden interruption of breastfeeding (Tapias 2006).

In many groups, it is thought that a newly delivered mother is quite fragile, and illness can be induced by others at this stage, for instance, in Islamic countries there is “*albasmasi*” (puerperal fever caused by an evil woman) or to the evil eye (Geçkil et al. 2009). In many groups, when the woman who is still breastfeeding becomes pregnant, she has to interrupt the practice as the milk “belongs to the baby *in utero*.”

Sexualization of the Breast

For centuries women have breastfed “naturally” as the baby demands to be fed, and mothers would show the breast while feeding the baby in public, even in Muslim societies (Ertem 2011). They might do it “in public,” in a park, a clinic, or in many other places. Children and adults observed the practice which was considered a “feeding situation.” In some Westernized countries, like the United States, the United Kingdom, and Ireland, there is a strong pressure to conceal this practice, as the breast is considered also as a sexual organ, and it is thought immodest and provocative to “exhibit” the breast (Gatrell 2011). Breastfeeding is thought “disgusting” or “animalistic” and this puts further barriers to breastfeeding. In shopping centers, there are now bathrooms or “private rooms” in which women are expected to go to breastfeed to avoid the social disapproval (Tapias 2006).

Kiss, Cup, Hand Feeding, and Pre-chewing of Food

Kiss feeding means that the mother feeds the baby from her mouth directly to the baby’s mouth. What is fed might consist of the mother’s saliva, which could be a strategy to keep the baby well hydrated if water is not available (Eibl-Eibesfeldt 1983). Also, a mother might drink a gulp of water, move it around in her own mouth in order to warm it up, and then give it to the baby as a way to increase its temperature. She may also pre-chew food, for an older infant, and then “process it” in her own mouth, before giving it to the baby in small portions which then do not require chewing on the part of the baby (Eibl-Eibesfeldt 1983). This is seen more frequently in less industrialized societies where there might not be access to machines that can process the food, or to “baby foods” produced at home or industrially. It is seen also in families of immigrants in the United States and other industrialized countries, and at times this practice is misunderstood as something disgusting or unhygienic or an odd behavior in the mother, which needs to be understood from its original context.

Hand feeding refers to a practice described in countries like Nigeria (Oni 1996) or Malaysia, in which a mother feeds liquid foods, or paps (a semiliquid preparation), to the very young infant by forming a sort of funnel with her hand and feeding the baby thus and slowly for maximum efficiency and introduction of more consistent foods. In the second semester of the baby’s life, the paps become semisolid.

Cup feeding (Lang et al. 1994) consists of the use of a small cup, plastic or metal (or the

"cupped hand") to feed expressed breast milk even to premature infants. This is a common practice in Nepal and many other poor countries, and has been introduced in others for the feeding of premature babies who cannot yet suck, but can be fed slowly from a cup, as a reflex allows them to "lap the milk" from the tilted cup.

Animal milk. Even though in the Western world people think it is very "natural" to feed infants cow's milk, other animals' milk has been and is still used in much of the world, such as goat, lamb, mare, yak, camel, and donkey, among the main ones. There are many historical precedents for this in Europe, where until fairly recently mare's milk and donkey's milk were considered as a health benefit for young children, and often given when the child was ill. Donkey's milk in Russia was used to prevent the transmission of syphilis (Radbill 1981). Among most Hindus, cow's milk is considered sacred and it purifies the body, since cows are a representation of a deity on earth. All of these animal milks are usually introduced after months of primarily breastfeeding. Often, given the difficulty in cleaning receptacles, the baby was placed directly to suck from the teat of the animal (Radbill 1981).

The Feeding Situation: The Nature of the Self- and the Co-regulation

The notion prevalent in many industrialized countries is that the feeding situation optimally involves a partnership (Maldonado-Durán and Barriguete 2002) and that the caregiver and the baby respond mutually to each other's behavioral and emotional cues, preferences, needs, interest in food, etc. This is a relatively recent development in terms of theory, although probably intuitive parenting has directed how parents feed their babies for centuries, following the infant's cues.

In our current notions in the Western world, optimally, the caregiver is responsive to the signals of the infant regarding hunger, satiety, timing of the feeding, and how the baby eats (fingers, playing with food, eating with a spoon, etc.). Feeding has been reported to be conducted very quickly and mechanically by caregivers for infants in orphanages, in which the caregiver has to feed many children and does so very "efficiently" and quickly, without conversation, playful interactions, but merely introducing food to the child as quickly as possible in the shortest time. Another phenomenon is force-feeding. Parents may see the infant as "not knowing" what is good for him or her and being distracted or just refusing to eat. Their point of view is that the calories and nutrients need to be introduced and they may resort to force-feeding to achieve it first and foremost. This has been described in the literature for infants in Nigeria (Dettweiler 1989), Malaysia (Launer and Habicht 1989), Bangladesh (Hamadani and Tofail 2014), and many clinicians report seeing that in families from India, Bangladesh, and also from Latin America. The cues of the child are ignored as not an important factor. In Malaysia, mothers may start feeding the baby rice-based purees very early on and later on force-feed the baby with nutritious food to ensure its growth.

The Feeding Situation and the Toddler

In many cultures around the world, people hardly ever eat alone. The mealtime even for adults is considered a social situation, a moment of exchange, not only of the food itself, but also of exchange of time, companionship, conversation, and sharing the experience. An adult would be hard pressed to eat alone in a restaurant, or it is not considered socially desirable. Increasingly in industrialized societies, the mealtime is a period devoted only to the consumption of calories and many people do it by themselves or in their car.

In most Asian cultures, the "Confucian" idea of the mealtime being an opportunity to "bind together" is followed traditionally. The same could be said of Middle Eastern, Latin American, and Mediterranean social groups.

In many cultures, parents prolong breastfeeding for over a year, and do not necessarily encourage the baby to feed him or herself at 10–12 months of age. They may prolong spoon-feeding for a long time, up to 3 or 4 years. In

Latin American families, it is common for young children to get a milk bottle during the day or to go to sleep up to 2 or 3 years or more. The child finds this soothing and the parents have no objection or pressure to get the baby to sleep on his own. The proviso in these cases is to encourage parents to brush their children's teeth in the morning, as the bottle during the night is associated with dental cavities.

Maternal Function and Obento Boxes

The eating of young children in nursery schools and preschools is a matter of great interest in Japanese culture. Children typically eat their lunch all at the same time and each one has brought from home an "obento box." This is a carefully arranged assortment of foods cooked especially for that child, presented in small pieces, each separated from the other in small compartments, and presented as beautifully as possible, representing small animals, or parts of nature. The ideal box should have a harmony of colors and be attractive, so that the child would eat the food in its entirety. Preparing the obento boxes is a matter of considerable worry and preparation for mothers, as it represents the quintessential maternal function, how she transmits the Japanese culture to the child, which includes the beauty, colorfulness, and freshness of the food, as this is "the Japanese way." From the obento box, the child infers implicitly the maternal care, and the school teacher is reassured if the child eats it completely (Allison 2013). There are multiple books and magazines for mothers (exclusively females in any case) on how to prepare these complicated products, many "new ideas" to make the food more attractive and a degree of competition between mothers on who prepares the most beautiful and elaborate obento boxes.

In highly industrialized countries, particularly in those in which both parents work and are very busy, and the children have multiple activities after school, "family mealtimes" are tending to disappear. Many clinicians lament this (Audehm 2011), as the mealtime could be a time for processing of everyday experiences, to discuss emotions and recent events, and to develop intimate communication as well as a time to enjoy each other in a satisfying fashion, while tasting delicious food.

Should the Young Child Be Thin of Fat?

There is some evidence that many Indian mothers prefer to give birth to a "small child," and also prefer the infant to be smaller in size and not to become "bloated." Indeed, Indian children's birth weight is among the smallest in the world (Yajnik et al. 2003). This has been thought to be a "thrifty phenotype," as mothers also tend to be small in size and very light in general. This tendency is currently being associated with adults who may be prone to diabetes of the insulin-resistant type. The issue is probably multifactorial, that is, associated with genetic and transgenerational nutritional factors, but there seems to be a cultural preference for small babies (Nichter 1989).

There may be cultural practices that might propitiate a child developing malnutrition. One controversial issue is that of veganism or vegetarianism. Not all traditional practices are necessarily good for a newborn or infant's growth or well-being. For instance, it was found empirically in some groups in Karachi, Pakistan, that mothers reported giving honey to newborns and "*ghutti*" instead of milk to reduce colic (Fikree et al. 2005). *Ghutti* is a herbal remedy that may contain honey or sugar and is prepared with water.

In contrast, a phenomenon of short stature and obesity has been described among Latino very young children born in the United States from Mexican parents. It is thought that this has to do with the change in the diet and level of activity that tends to be prevalent in the United States. Immigrant parents, often having come due to economic deprivation in Mexico, have access to "cheap calories" in the form of "junk" food and these sugary foods and sodas have a high content of carbohydrates and relatively less proteins. Parents who have experienced deprivation as

children may be prone to satisfy all the wishes of the toddler or preschool child for such sugary junk food. As the lifestyle is more sedentary, children become obese and short; the low stature is related to less consumption of proteins. Perhaps parents wish to give the children what they did not have. In the United States, a recent survey revealed that a majority of young children eat excessive amounts of calories and fats as well (Saavedra et al. 2013).

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Infant and Toddler Crying and Irritability: Cultural Meanings and Responses

15

J. Martin Maldonado-Duran and Felipe Lecannelier

Fig. 15.1 Mother soothing baby. (Original artwork by Ana-Marcela Maldonado-Morales)

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Introduction

Not always, but most of the time, the terrestrial life of the newborn (after the aquatic existence in utero) starts with crying. This first act is celebrated by the mother and those in attendance as a visible sign of life and that the baby has survived the difficult process of being born. Usually, vigorous crying at that time is thought to be a sign of health as the baby needs to "expand the lungs." Crying behavior then will be with the individual through his or her life, carrying different meanings and reasons. Usually, the crying is triggered by powerful emotions. Is it possible that some cultures accept and welcome those intense emotions, while others don't? There are stereotypes about some cultures having a "stiff upper lip" and not showing "weakness" by crying. There are other cultures which people associate with intense emotionality, like in the Mediterranean peoples. Could the attitudes toward emotion—and crying in particular—influence the perception of crying in the mother and the infant?

Incidentally, in many cultures it is thought that pregnant women "cry easily," and they are readily moved by emotional experiences. Also, many future mothers and fathers cry when they first see their baby in utero during an ultrasound and everything is normal. Clearly, when the baby is born, mothers, fathers, and bystanders cry for joy in many cultures, so there is a strong association of emotion with these momentous episodes of transition.

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Crying in the infant and young child is examined here in the light of physiological and survival value for the baby, as an instrument of communication and signaling, a mechanism to promote attachment (Soltis 2004), and the responses of the "receivers" of those signals. The receptors of the crying may have a variety of reactions to the baby; these may go from compassion and empathy for the infant, to ignoring the child or to be annoyed and angry at the baby (Out et al. 2010). There may be other interpretations, like a signal of pain, feeling bad in another way, boredom, wanting attention, etc. The culture of the caregivers has an impact on the perception of the crying, in addition obviously to their own personal history as children and their reactions as parent/caregivers of the baby.

Those culturally informed reactions may well influence the course of the crying and the way the infant is responded to. The mind of the infant, as we now know, is literally being formed during the first few years of life, hand in hand with the migration of neurons and the formation of interneural connections and memories.

Responses go from sensitive ones to more hostile ones. The most dangerous or extreme may include shaking and hitting the baby, if the parents are driven to exasperation by excessive or persistent crying (Bensel 2010) and are angry about it (Soltis 2004), or they have no psychosocial support. If parents interpret the crying as a deliberate act of the baby to annoy the parents or give it another malignant attribution, the negative response is more likely. We explore different scenarios in their cultural significance and strategies to assist parents in dealing with the crying in their baby and young child.

Crying in principle is a normal phenomenon in the newborn immediately at birth, and from then one for the first few years of life. It is a serious problem for a proportion of infants and families. In several cities in the world, there are "hot lines" or "warm lines," i.e., telephone lines, which a caregiver can call to get support to deal with the crying. It is known that isolation and dealing alone with an infant who cries incessantly can have negative consequences. The person on the other side of the line attempts to assist the caregiver to try different strategies to calm the baby and to alleviate the sense of exasperation in the caregiver. This illustrates how crucial this issue can be for the interaction and relationship between the infant and his or her caregivers.

Infant Crying from the Ethological Point of View

Crying is the primary strategy the infant has to communicate distress or the need for care by someone, usually the parents. As the child gets older, crying is also a signal that can occur due to anger, sadness, fear, and frustration. It may be a principal way of expressing discontent or it can come from physical pain. The toddler may express frustration, anger, and feeling overwhelmed, by means of a temper tantrum, which may last a few minutes or longer, in part depending on the response of the caregiver.

From the ethological point of view, crying can be viewed as the primal behavioral repertoire of the infant to elicit care (Zeifman 2001) similar to begging signals and noises of distress in other mammals and birds, all of which have an important survival value. Crying in the very young infant does not seem to have the same meaning as it does in adults, in which it can be due to sadness, and at times from compassion or even intense happiness.

Crying is a primal "animal behavior" of infants. Among many bird and mammal species, the youngster has an innate signaling repertoire to elicit or "release" parental behaviors such as feeding, appeasing, and physical proximity, or a protective response. One such example is in hatched chicks, which open the beaks in an extreme way and create in the adult bird the peremptory need to search for food over and over, and to feed the offspring one by one. The "releaser" may be the open beak and the color of the mucosa that triggers the instinctive response in the adult bird. In mammals, the infants search for the source of milk in the mother, who patiently "allows" or assists some of the young to feed. This creates a state of calmness in the

young, only to repeat the cycle after a certain period of time. The parent cannot escape those responses, although there are certainly some adults that reject their young and do not feed them or even kill them. This "instinctive" behavior depends on a series of factors, which include visual signals, olfactory signals, tactile and auditory ones, pheromones, the release of chemical neurotransmitters, and a behavioral repertoire that alleviates the distress signals in the young; in turn, this alleviates the distress in the adult, and this constitutes a reward system for the adult and the youngster.

It is known that adults from the same species or other predatory animals prefer the "easy prey" of the young in birds and mammals. The adults go to great lengths to hide their offspring and to keep them satisfied, as otherwise they also signal their presence to potential predators. While the young's signal of crying releases the parental behavior of protection and feeding, it can also signal the presence of an "easy meal" for predators. There is an "urgency" to appease the crying of the young to avoid a negative outcome, even beyond palliating the infant's needs.

In humans, numerous studies have demonstrated a "stress response" in the mother of a crying baby (Swain et al. 2011), which can be shown physiologically through a number of measures (Swain 2011), a response which is "released" or brought about by the cry of the baby. The cry signal first has to be perceived. Normally, the caregiver (the mother is the most studied one) experiences an activation of brain centers that in turn activate serotonin and oxytocin releasing centers. Serotonin is thought to help in perceiving and focusing on the crying, elucidating what is happening. Oxytocin, also called the "hormone of empathy" generates a compassionate response (Leng et al. 2008). The stress that is generated by the crying is mediated by cortisol, a stress hormone in the caregiver. Once a response is produced, the opioid system is the "reward" for the parent once the baby is calm. Swain (2011) has proposed a "cascade" of events that includes hypothalamic-midbrain-limbic-paralimbic-cortical brain circuits that are activated selectively and sequentially during times when the maternal brain is "switched-on" by baby-cries (Swain et al. 2007).

Most of the time the parental response consists of attempting to alleviate the distress of the infant, through feeding, carrying, or physical proximity, which often diminishes the crying response. However, even in the animal world, there may be distorted maternal responses *vis-à-vis* the crying of the baby, eliciting, for instance, anger, or maltreatment instead of nurturing or protective responses. This is influenced by additional stress for caregivers, as well as early life experiences which may create distortions in the neurophysiology of the response described above, and instead of generating empathy, it generates a hostile response or no response at all.

Several studies suggest the reciprocity of responses between the mother and the young infant (Kivijärvi et al. 2001). For instance, the tendency for mothers to carry the baby on the left side, and the high frequency of feedings at the breast; there is evidence of a "let down reflex" when the mother listens to their child's crying, her milk is "let down" or descends to engorge the lacteal alveoli into the breasts and they are engorged with milk for the baby to feed.

Developmental Aspects of Infant Crying

During the first 2 or 3 months of life, infant crying has a "tonic" quality that readily can be identified as the typical crying of a newborn or very young infant. The baby typically changes and becomes much more social, relational, and smiles at those around him/her at around the age of 2 or 3 months. From this time on, the crying becomes more "phasic" and more related to conditions such as hunger, a painful stimulus, being cold, need for interaction, that is "being alone," or needing to be contained and soothed or fed.

As the infant grows older, he or she will develop observable attachment behavior after 6 months or so. The infant then establishes an exclusive relationship with specified caregivers, with whom the infants feels safe, protected, and

contained, but not just any human being anymore. Shortly after, around the first year of life, there is more intentionality in the infant, and the search for more "autonomous" behavior, trying to feed himself, and having more agency and need to do something he or she wants (Papousek 2009). The child may cry from frustration or when a wish is not met. Still later on in that second year, there may be crying in anger, leading to temper tantrums. Therefore, the causes of crying and its manifestations will vary with this maturational process.

How much crying is normal for a baby? Even though this seems a simple question, there is wide variation on the amount of time babies cry in different cultural groups. Some studies have found an enormous difference, tenfold if one compares time of crying between babies in England or the United States on one side, and babies in some regions of India or Africa (St James-Roberts et al. 1994). Indeed, it has been shown that increasing carrying of the young infant is associated with lesser duration of crying per day (Hunziker and Barr 1986; Bensel 2006). Carrying the baby is practiced in most traditional societies for extended periods of time during the day, compared with the typical regime in the United States or the United Kingdom. In the more modern societies, parents may resort to the use of a pacifier to help the baby remain calm (Kramer et al. 2001). The use of pacifiers is discouraged by the World Health Organization due to its perceived interference with breastfeeding in a "natural" environment; contradictorily, it is incentivized by the American Academy of Pediatrics as a "safe sleep" practice.

The lesser duration of crying per day has been associated with the fact that there is a more "proximal" approach to caregiving between the mother and the baby. The mother (a grandmother or an older sister) may "wear" the baby and maintain physical contact for extended periods of time, in which the baby sleeps or is awake (Hewlett and Lamb 2002; Nelson et al. 2000). The mother may work and carry the baby on her back, as is done in many traditional cultures, such as Mexico, Guatemala, and many others in Latin America, as well as in Asia and Africa (Gottlieb 1995).

In contrast, in the modern Westernized societies mothers tend to put the baby on a crib or a carrier, and may sleep separated from the child, waking up during the night to soothe him or her, and giving the child an opportunity to self-soothe, before one proceeds to carry the baby (Brazelton 1990).

It has been suggested that in modern cultures there is a "mismatch" between the evolutionary programmed behavioral repertoire of the infant and the demands or practices of modern life, in which the baby cannot possibly be carried around most of the time (Bensel 2003, 2006). Parents have to resort to devices such as a pacifier, a swing, a machine which makes breathing-like noise, a monitor, music, etc. in an attempt to substitute for the constant contact (Trevathan and McKenna 1994).

It must also be taken into account that when the crying is long lasting or very intense, this also sets the baby's body in a state of stress, and when this is repeated day after day, it may have negative consequences in terms of stress hormones and in the central nervous system (Hassenstein 2001).

The repeated experience of the infant of being soothed when he or she is in distress may lead eventually to the expectation that "someone will respond" when the baby is distressed. The repeated presence of the caregiver in turn leads to a perception of the caregiver as a "helpful person" in times of distress and is a part of the attachment system: the capacity to trust the other and rely on a few caregiving persons who alleviate distress and help regulate the young child (Swain et al. 2004). It is hypothesized that crying, which is a behavior that persists through life, is a powerful signal to elicit attachment behavior, i.e., a soothing response from the receiver of the signal (Nelson 2005).

Cultural Factors in Infant Crying and Caregiver Responses

Even with a "pre-programmed" or "wired" behavior such as crying, there are different responses to the phenomenon which are dictated by culture. What "should" a mother or caregiver do when the baby cries? How quickly should she

respond? Should other caregivers respond? Can the baby "soothe him or herself"? What is the meaning of the crying itself, or why is the baby crying? Why do parents in some cultures are afraid of "spoiling the baby" if the child is carried when she or he cries?

In the United States and many other parts of the world, grandmothers and other experienced relatives often warn parents against responding too quickly to the crying. They fear the baby might get used to being held and then cry all the more, if he or she is not in somebody's arms at all times. Is this a real phenomenon or just a fear based on traditions?

Several studies have shown that in a culture where self-reliance and independence are promoted, when parents decide to adopt a "more proximal" approach, i.e., soothing, carrying, and containing the crying baby, the intensity and duration of crying is significantly reduced (Hunziker and Barr 1986; St James-Roberts et al. 2006).

Indeed, behavioral psychology tends to see crying as an inherently aversive or undesirable behavior (Nelson 2005), which should be discouraged or not reinforced. The notion is that not responding to the crying, would "not reinforce it" and then it would disappear. A similar theory is applied to temper tantrums in young children. However, it could be argued that just "giving up" and realizing no one will be there to soothe a child may not be a desirable developmental outcome, i.e., the realization that nobody will hold him or her, and that therefore, there is "nothing to share," i.e., the tears (Kottler 1997).

Immigrant parents who bring with them their own traditional practices and traditions to the host country, may be torn between following their own old strategies and the "modern" or Westernized recommendations, against swaddling, breastfeeding the baby whenever he or she cries, or being given the recommendation to give the infant the opportunity to self-soothe.

Pediatricians may in such situations, recommend avoiding traditional remedies such as giving the baby "gripe water" (an infusion made with ginger, fennel, and dill principally) or other infusions to calm the infant: commonly used infusions are made with chamomile, vervain, licorice, and balm-mint. Their effects depend on numerous variations in their preparation and all the actual ingredients in the beverage given. In Mexico, mothers often recommend giving the baby a bath in a small tub with lettuce leaves (Maldonado-Duran et al. 2002). It is hard to evaluate the efficacy of these remedies, and it is likely that there is a significant placebo effect (Garrison and Christakis 2000). Parents may be confused on whether they should use them, as their elders may recommend them, as opposed to following the pediatric advice.

Rather than a purely physiological phenomenon, crying in infancy is highly dependent on interpersonal context, and specifically on the quality of the parent infant relationship (Papousek 2009). Parental behavior is dependent on intuitive responses, influenced by cultural practices transmitted from generation to generation.

Normal Infant Cry

How much crying is normal for a baby?

The lesser duration of crying per day in traditional cultures has been associated with the fact that the mother "wears" the baby or carries the child on her body (for instance on her back) most of the time or for extended periods of the day (Gottlieb 1998), with multiple devices. Several authors have suggested that the evolution of crying in the human infant is an adaptation to the need for frequent feedings, as the human milk is comparatively a very diluted one (Barr et al. 2000). As a result, the baby needs be fed frequently. The mother finds that the breastfeeding helps to soothe the baby, resulting in greater changes of survival for the latter. When there is a less "proximal" care, the baby will cry much longer in a 24 h period.

Infantile Colic

In most Westernized societies, infantile colic is well-known although it by no means affects all babies. This condition has not been investigated in many non-industrialized areas. In fact, in a study in Korea, where there is more "proximal

care" an empirical study did not show an increase in crying nor the state that we call colic (Lee 1994). It consists of periods of intense crying in the baby during the first months of life. Infantile colic is usually self-limited and disappears by the fourth month of life. Often, the intense crying occurs not only in the evenings, but also at other times. The crying can be difficult to calm. Parents resort to carrying, patting, taking the baby on a ride, swinging the baby on the caregivers' arms, placing the baby over a vibrating washing machine, etc.

The available studies find that the prevalence of colic is between 5% and about 20% of babies (Tarasco et al. 2012). The name "colic" is the result of the thought that the crying is related to the intestines, like problems in the contraction of the gut that causes pain to the infant. However, the cause is not known. It seems that there are multiple factors, from maternal depression, increased levels of stress in the parents, neurological conditions (such as a proxy to migraines), to hypersensitivity to pain in some infants. There may be an alteration in the intestinal flora, or a negative reaction to cow's milk which is used to prepare formulas among many other candidates (Tarasco et al. 2012). It is not clear whether it is associated with increased content of gas in the gut, or whether that might be the result of the crying itself.

When the crying lasts longer than 4 or 5 months, it is referred to as persistent and excessive crying.

If culture influences the normative responses to the usual crying behavior of the infant, this is even more pronounced when the baby cries intensely, persistently, or for a prolonged period of time, i.e., excessive persistent crying, or when a baby is thought to have colic. An indirect but important correlation with excessive crying in infant is the exposure of the baby in utero to the effects of severe psychosocial stress in the mother and depression during pregnancy, both of which have been associated with a higher prevalence of excessive crying in the infant (Van den Bergh 2005; Vik et al. 2009).

In practical terms, one could say that in Westernized societies, a majority of infants will manifest increased crying around the second or third month of life, which then will improve and is the hallmark of "colic." However, several researchers have emphasized (Bensel 2010) that in less technologically complex societies the concept of colic is not known. In those cultures, it is also commonplace that the baby is in constant contact with the body of his or her mother during day and night.

Brazelton et al. (1969) and others noted that among the Mayan ethnic groups studied, infants appear very calm and cry very little, they seem very responsive and content. This responsiveness of the mother and the concern about crying might have multiple reasons.

One of the reasons among the Maya is the belief that infants are very fragile and that crying might bring about the loss of the soul. This may be strongly associated with the ever-present danger of high infant mortality rate in developing countries and traditional societies.

Mayan mothers can be very concerned about the possible loss of the soul of the baby, whose soul could easily be lost or fragmented. When the baby cries incessantly or excessively, often the diagnosis is made that the baby has lost his or her soul (Brazelton 1977). Soul loss is a frequent condition that affects children and adults. Soul loss is a common belief in Peru, other South American countries, and Bali.

One has to always take this possibility into account. For instance, among some mothers of the Zinanteco group in Southern Mexico (Brazelton et al. 1969), when the mother gets up from a place where the baby has been put on the floor, she brushes the ground with her *rebozo* (shawl) in order to gather possible parts of the soul that might have been left on the ground. Also, if an infant or toddler falls, there is a danger that the soul may be lost not only from the fright but also from the physical contact with the ground.

Culture-Related Explanations for Infant Crying

It is clear that for such an important phenomenon as infant crying, and particularly if it is intense, excessive or persistent, different cultural groups

would offer various sorts of explanations as to why the baby is crying.

An important one relates to some traditional cultures such as some members of the Beng, in the Ivory Coast, a small country in West Africa (Gottlieb 1995). In that group, like in many others around the world, it is thought that babies come from the world of ancestors, from the underworld or from the spirits in the woods. As such, they have to be persuaded to want to "stay in this world" rather than go back to the spirit world, where they might long to be, as they were happy there. Faced with the crying, parents may wonder first if the baby might be thirsty or require increased carrying or more sleep. If those measures fail, the child should be taken to a diviner, who is in communication with the spirit world. A theory pronounced by the diviner may be that the baby has "forgotten a piece of jewelry" that she liked very much while she was living in the other world. Then the caregivers endeavor to persuade the child to let go of this, compensate her, and make her happy in this world.

In many cultures, babies are thought to long to go back to the other world, and that they may have a sort of sensitive period in which they are still fairly recently arrived in this one and are more vulnerable to return there (by dying). Parents may resort to many measures to convince the child to stay here, such as singing, dressing the baby with beautiful clothes or trying to entice him or her with jewelry and caresses to stay here (Gottlieb 2016). In other African groups, the baby is thought to be very vulnerable to be taken away by spirits who always want to take babies, and they have to be "fooled" by making the newborn as ugly as possible, undesirable, covering the infant with mud and giving him a derogatory name, such as "dog" or "dirt," which only will be changed once the baby gets older.

Infants may also cry because they are thought to be able to see scary things, such as demons, bad spirits, or ghosts, which most adults cannot see. In the United States, many parents think that babies can see angels and this can make them smile. In others, the observation of an evil spirit or an evil angel might make the baby cry. In the Christian tradition, babies are thought to have a "guardian angel," who watches over the child for the rest of his or her life.

As noted previously, *susto* (a fright), evil eye or soul loss can be diagnosed among many cultures as the cause of the infant crying. Once the diagnosis of soul loss has been made, the curandero or the midwife has to be called to bring the soul back into the baby. The soul has to be "grounded" into the child so to speak. It may be thought that the soul is wandering around and has to be called in a soul-calling ceremony in the house. Brazelton described, among the Maya of Mexico, a common practice to deal with this, which is putting cold water in the baby's mouth and then calling the soul at the door of the house. The baby is brushed with pine branches dipped in water and the house is smoked with incense which makes a path for the soul to find the body.

In different cultures, other explanations for infant's intense or persistent crying may be offered. These are informed by folklore and tradition. For instance, in some groups in West Africa (e.g., the Yoruba in Nigeria and the Bariba in Benin) the baby who cries abnormally may be suspected of being an "ambiguous being" or possibly a witch child. The elders or a shaman, or the parents may delay naming the child until it is decided if the baby is human or should be selectively neglected if it is decided that the baby is indeed "a witch" (Sargent 1988). Among members of the Shona group in Southern Africa, the baby who cries excessively is suspected to be under the influence of evil spirits; home remedies or the presence of a shaman may be necessary to deal with the crying (Gwandure 2006). *Caida de mollera* (sunken fontanelle), another "folk illness" in Latin America, can be associated with intense crying in the baby.

Some Remedies for Crying and Colic: Soothing Strategies

Among families of many traditional cultures, mothers breastfeed their baby on demand and might also put the baby to the breast for soothing purposes, to alleviate almost any form of distress or crying in the baby (Pinelli and Symington

2010). The same occurs with the use of sucrose and sweet flavors to improve the distress of the very young infant and diminish crying (Boyle et al. 2006).

There are some traditional remedies to deal with a baby who cries intensely or has "colic." The most immediate remedy which has been documented in many groups is to breastfeed the infant (or in cultures where a pacifier is considered acceptable, through a pacifier). This has been observed in Latin American countries, particularly in the aboriginal population, as well as in the Middle East and in Asia. Usually, the baby is fed on demand, or if not feeding, the breast is given for "suckling" as a calming strategy. Sometimes, this is done by a female relative and not always by the mother.

Another remedy is swaddling, practiced in many traditional societies in Asia, among the Middle Eastern populations (Zahr and Hattar-Pollara 1998). This also has been described in Turkey, Latin America, in the United States among the Native American families (Nelson et al. 2000). Swaddling is being used again by parents in the United Kingdom and the Netherlands as a "novel practice" which helps with regulatory disturbances in the infant, often associated with excessive crying and sleep problems (Meyer and Erler 2011). Crying during the night is closely associated with the strategies used by caregivers to promote sleep, which is often associated with crying when the infant wakes up in the night, particularly in the younger child. Many cultures that practice swaddling also tend to co-sleep with the baby. In fact, babies who are swaddled tend to sleep with less disruptions and have longer deep sleep periods (Franco et al. 2005).

In the Western medical world, there are no specific, proven remedies for colic. Methylscopolamin, a medicine to diminish the intestinal movement, has not been shown to be helpful, except anecdotally. The same can be said of simethicone. In Italy, physicians tend to use cimetropium bromide which they find useful (Savino et al. 2002).

A Chiropractic manipulation of the back is also attempted by parents to alleviate the crying (Lucassen et al. 1998). Dietary interventions are often recommended like avoiding cow's milk (in the formula), or simply changing to another formula as the first intervention if the baby is not breastfed. The pediatrician may resort to a soy-based formula as well as lactose enzymes (Garrison and Christakis 2000).

Families may "cleanse" the baby from negative influences such as the evil eye, envy, and other negative influences. Numerous things can be done, like cleansing by a shaman, being "cleansed" at home with an egg or through other amulets, praying, etc.

The baby may be protected from these influences by protective amulets or adornments of a certain color, blue in some groups, red in others.

Excessive and Persistent Crying

Some infants continue to cry for long periods of time (longer than 3 h per 24 h), over 3 days per week and which lasts more than 3 months. This crying may persist for months or even after the first year of life. This prolonged and persistent crying affects up to 15–25% infants in studies conducted in the West (Wehrstedt 2011). The infant can cry for 8 hours or more during the day/night, intermittently or continuous (Bolten 2008). Studies in the United States, Germany, the United Kingdom, and other industrialized countries have found a similar prevalence. When a baby cries for prolonged periods of time and is inconsolable, the child is at risk of being mistreated (Reijneveld et al. 2004) including spanking, shaking, and physical abuse in general as the parents may become desperate, being unable to soothe him or her.

Another predisposing factor is a high level of stress and anxiety in the expectant mother. These are unfortunate associations, as precisely a mother who is depressed or stressed may deal well with a very placid and calm baby. Instead, she will have to deal with a baby with regulatory difficulties, sensory integration problems, and who will not be easily soothed despite her best efforts. This can lead to a vicious cycle of frustration and lack of self-confidence in the new mother.

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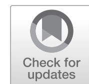

16 Interpersonal Conflict and Discipline of Young Child

J. Martin Maldonado-Duran and Juan Manuel Sauceda-Garcia

"What counts in making a happy marriage is not so much how compatible you are, but how you deal with incompatibility."
(Leo Tolstoy)

Writing about power differential in a marriage or partnership, or about the power differential between parents and children, and what are the vicissitudes of these differences is perhaps too ambitious and at the same time hazardous. As we suggest in other chapters, people tend to be very certain about the correctness or benefits of their own culture, and more suspicious and skeptic or suspicious about what "people of other cultures do." In clinical work with parents and children in the perinatal stage, infancy, and early childhood, these issues come to the fore as the young couple is trying to establish a "philosophy of parenting" and also a set of strategies to resolve differences of opinion, disagreements, or conflicts between the spouses. These issues are strongly influenced by each individual's personal history, and experiences during childhood and, later on in life, by sociological and economic issues, which have a powerful impact on the availability to resources and the quality of life of the parents, and as well as by their cultural background. From the start, we emphasize we do not cover issues of child abuse and neglect, but merely "discipline" of young children, even though it might be quite harsh and some might consider some common or normative forms of discipline as maltreatment. Neglect is another complex problem that is outside of our scope.

We focus on examining some of the main issues that pertain to cultures, without pretending that they are not intertwined with personal history or with economic and stress factors for a given family, as the behavior of the adults and children will be impacted by all these correlated elements. Still, we wish to suggest some important cultural issues that play a significant role on how parents think, feel, and act regarding the marital or partnership relationship, as well as on how they will try to teach important values and norms to their children, and how they will set limits or discipline them.

Marital Conflict and Domestic Violence During the Perinatal Period

The Transcultural Nature of All Marriages and Partnerships

All marriages and partnerships are transcultural, this is a well-known principle commonly employed by family therapists. Even in the

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most homogeneous community from an ethnic, linguistic, or cultural point of view, there will be important differences between the spouses in many areas. This is an issue that all couples will face: what and who should do the various tasks in the family? Who will manage the money or accounts, and whose money is it? How should the children be raised? What values are going to be taught? How will the members of the couple resolve (or not) differences of opinion or major disagreements?

The marital relationship is strongly influenced by life experiences, which in turn are also determined by the cultural background of either individual. Cultural beliefs and practices will illuminate and guide what the "husband should do" what "a mother should be like," etc. These questions will occur even in the most "homogeneous marriage" or partnership.

It is to be expected that the beliefs and cultural influences might be more intense in the case of members of a couple from very different backgrounds. With increasing migration and multiculturalism, young parents will decide to marry people to whom they might not have had access two generations ago, in which social groups were more homogeneous for the most part. Nowadays, a Muslim man from the Middle East may marry a woman from Western Kansas, or an atheist woman from Europe may establish a partnership with a very Catholic person from Latin America. Even the expectation of whom one should "marry" is influenced by culture: what are the expectations of each member of the couple going into the marriage or partnership? Did they marry for love? Did he or she select a person precisely from a "very different background" in order to get away from their own culture, norms, and beliefs?

Each member of the couple will bring a set of values, norms, ideals, practices, and expectations some of which are conscious and most of which are unconscious or "implicit." These may come to the fore or become more salient only when the couple starts living together, or when the woman becomes pregnant or when the first child is born. Although many conflicts and differences of opinion may be resolved because the spouses love each other, there may be important differences or situations that may lead to an *impasse* or conflict.

It would be ideal if couples reflected on their beliefs, values, and expectations before the union, so each one would understand the other person's point of view and try to come to agreements or compromises beforehand.

This idealized view, however, is also biased. Many people would say that obviously in any marriage (even in the United States a generation ago) "there is no doubt that the couple should do what the husband says" or "he has the last word on all important decisions." This applies in many cultures. Another question is whether each spouse owes more allegiance to his/her biological parents or to the spouse. Also, who in the extended family "may dictate what the new couple should do." In all cases, differences or even conflict are unavoidable. How these issues are approached, resolved or not, may lead to harmony or chronic marital discord, emotional distance, separation and divorce, or enduring a life of dissatisfaction in an unhappy marriage.

Common Conflicts in the Perinatal Stage

Marital Satisfaction and Having Children

A fairly well-established finding in marriages in the Western world is that the couple's satisfaction with the marriage tends to diminish when the couple has their first child (Keeling and Pierce 2007; Shapiro et al. 2000; Twenge et al. 2003). In many cases, the newborn is an unexpected newcomer, or the family is barely prepared to the multiple adjustments that are required when one has a child (Wendorf et al. 2011).

Empirical research on marital satisfaction suggests that this indicator goes down after the first child and continues to decline with the second one, and diminishes even more with further children (Lawrence et al. 2008; Twenge et al. 2003). This may be related to the sacrifices required in the new role, (not only being a spouse

but a parent) and the constraints and restrictions that having children represents in many cultures. There is some evidence that in the West, perception of unfairness in the marriage regarding household work, and less "quality time" spent with the husband contribute to the dissatisfaction of the new mother (Dew and Wilcox 2011).

Sexuality is another source of conflict. Different cultural groups have varied proscriptions for the nature of sexual intercourse, particularly toward the end of the pregnancy (Bartellas et al. 2000). These cautions or taboos may or may not be shared by both members of the couple. A frequent scenario in many cultures is that the male wishes to continue to have intercourse, while the woman may be cautious, not wish it, be afraid of it, or fear negative consequences for the pregnancy. This may lead to concerns about marital satisfaction and the man "seeking satisfaction elsewhere" as well as jealousy and resentment. In some groups, this may be more or less accepted as "the way men are" or there may be conflict because of infidelity, and pressure on the pregnant woman to engage in intercourse for fear of negative consequences. In many cultures, there is a perception that it is a woman's "duty" to satisfy her husband, and his view that he is entitled to have satisfaction at any time, even though more or less forced intercourse, given the diminished power status of a majority of women all over the world (Varma et al. 2007). This is still observed even in highly urbanized and educated couples, as well as in traditional societies.

A study with over 250 pregnant women (Naim and Bhutto 2000) found that a majority of women thought the frequency of sexual intercourse should diminish during pregnancy, and about 50% of the women thought that it was possibly harmful to the baby *in utero*. In Islam, there is no proscription of coitus during pregnancy, as long as the woman is not bleeding, in which case she is considered impure.

Aside from sexuality, men in many cultures experience jealousy of the mother's attention and focus on the pregnancy, and once the baby is born, on the needs of the infant. This may make the man feel he is being relegated, and to fear that he has lost his place. There may be feelings of envy and anger, or "competition" with the baby (Mezey and Bewley 1997). In most modern families in the Western world, it is expected that the man should be supportive toward his wife and future mother of the baby, and when this is absent, it may contribute powerfully to depression and increased stress in the woman.

Domestic Violence During Pregnancy

Domestic violence unfortunately exists in all societies and socioeconomic strata. It would seem that pregnancy may alleviate the problem of violence, as men may think it is unacceptable to hit a pregnant woman. Some women even seek pregnancy as a means of protection. However, in other cases, it precipitates the violence. The violence most often occurs from the male partner toward the female, as she is usually in a position of more vulnerability and less power. The prevalence varies enormously among studies. It is hard to conduct such inquiries as there are issues of secrecy, shame, and even legal consequences, so the true prevalence is believed to be often underestimated. In fact, what is considered *domestic violence* is a crucial issue. Should it include not only hitting, but also insulting, psychological pressure and severe control, constant criticism and demeaning, as well as forced sexual activity? We include all these in this review. Aside from the emotional effects on the woman and the relationship, the violence affects the course of the pregnancy, leading to a higher risk of perinatal complications, preeclampsia, kidney disease, and that the newborn will spend time in the neonatal intensive care unit (Silverman et al. 2006).

A recent survey conducted in Bangladesh reported that over 75% of women had experienced domestic violence (Silverman et al. 2007). In a recent large study in Iran (Hassan et al. 2014), 72.8% of women reported violence during pregnancy. The prevalence figures in Latin America are similar (Castro et al. 2003; Moraes and Reichenheim 2002), as are those in African studies. In the United States, it is estimated at around 15–20%, and in Britain at around 25% during pregnancy (Mezey and Bewley 1997).

A study with 500 random pregnancies in India found a prevalence of about 25% of physical violence during pregnancy. The predominant injury was reported to be the head, neck, and abdomen, and a majority of women rated such episodes as "recurrent" (Purwar et al. 1999). Severe marital conflict and violence also contribute to the woman being depressed, very anxious, and to develop symptoms of posttraumatic stress disorder (PTSD).

There are many alleged reasons for domestic violence during pregnancy, some of which have been studied from the point of view of the man and the woman. The "explanations" are strongly influenced by culture. An important determinant is the conception of masculinity, and what a man should do. Sometimes, it is conceived as total control over one's property (the woman), not being challenged, disobeyed, or questioned. Some men say that violence "ends arguments more quickly" and helps to hide emotions and weakness (Mansley 2009). Mansley (2009) has highlighted how some African American men who grew up in violent and impoverished neighborhoods and a saw violence at home, tend to show masculinity through gaining respect, inspiring fear, intimidating and being tough at all times—all of which they experienced while growing up. In the United States, Caucasian men may engage in domestic violence, with feelings of entitlement, "white privilege" and a biased view of masculinity as control and power (Kimmel 2013).

In many cultural groups, women dislike the violence, but often feel it is expectable, unavoidable, and even "their fault" for "provoking" their spouse. Included among the "provocations" listed by many women in traditional societies, are burning the food, going out without permission, not wanting to have sex when their husband or partner wants, disobeying him in other ways, even contacting relatives without his permission. Of course, these same issues occur in "modern" cultures, although usually women will generally say that the violence is mostly not justified due to those "transgressions." There is a lot of violence that occurs behind closed doors in suburbs, and it is never spoken about, reported, or resolved.

If one were to understand any culture-specific aspects of domestic violence, it might be possible to consider intervention strategies that might be more applicable or even effective within different couples or groups in terms of prevention and intervention. One issue that puzzles many well-meaning interventionists is the fact that women "return to the abuser" after he promises repeatedly to change, only to repeat a cycle. This is based on the cultural conception of the marital bond, the psychological representation of what is a family, and the view of how men and women are. Other issues are "bearing a cross," dealing with one's fate, paying for previous infractions (e.g., in childhood or in a previous life), and destiny (God's will). A crucial determinant is financial, how the women would support the children if she were to leave her partner.

Given the nature of extended families, it is important to consider that violence against a pregnant woman may also be carried out by relatives, for instance, the parents-in-law of a woman, or other people in authority, as it is, for instance, in some areas of India (Khosla et al. 2005). This violence occurs in many cultures where there is intense interaction with the extended family and in very hierarchical societies.

Much work remains to be done to understand the frustrations of men and women in the perinatal period. The interventions have to be carried out within the cultural context, rather than expecting that women with very little real power and financial means might just "leave their husband" in a culture in which single women are stigmatized and face the obstacle of balancing work and child care. One set of values cannot be applied to all cultural groups. Women are oppressed in most cultures, in more subtle ways in Westernized societies, and any attempts at prevention and intervention have to take this issue into account.

Discipline and the Young Child. What Is the Purpose of Discipline?

In many parts of the world, mothers, fathers, and others are interested in "how to parent" their young child. In others, there is no question about this, as tradition dictates certain measures to

instill values and curtail negative tendencies in young children. Many parents learn from their own caregivers how to deal with their child. Other caregivers who suffered as children with their parents try to do the opposite of what they experienced in childhood.

Discipline is rarely an issue in the first year of life, but as the child becomes more willful, mobile, curious about the world that surrounds him or her, parents think about how to set limits to the child, help the infant to behave adequately according to their age. They often want their son or daughter to adopt the behaviors and attitudes that they think are "optimal" or suitable for a young boy or girl. In industrialized countries, parents are often eager to find books and resources that help them deal with issues like temper tantrums, a strong-willed child, how to get children to be more compliant, and there are multiple "parenting programs" that promise to help with these issues.

When parents seek resources on how to deal with their children, it should be clear that there is limited scientific evidence of what are the "best techniques" to deal with children. There is much more knowledge about what "not to do," that is, what strategies have a negative impact on the emotional life and behavior of children (such as severe physical punishment, harsh parenting, very authoritarian parenting, emotional neglect and abuse, physical and sexual maltreatment) than there is about what one "should do" to promote an optimally functioning and happy child. The variables are multiple and there are so many factors that it is unlikely that "one approach" to parenting would be adequate for the different temperaments, children's reaction, styles, and attitudes.

Often, parents fall back on the strategies they learned during childhood, seeing their parents apply them, and in many areas of the world this is not even a question, parents just implement the discipline that "everyone else" uses, without question and without much thought about the "fit" between a particular child rearing style and the individual child. This is particularly so in cultural groups that consider all young children as "more or less the same" and do not see them as much as very unique individuals with preferences and styles of reacting.

Even with these "new ideas," parents everywhere often resort to the techniques and strategies that they learned from their parents or that they learned as children. They do so consciously or unconsciously, even if at times an adult thinks one "does not want to be like one's mother was," and in moments of stress it is common that parents realize they have employed strategies that they endured as children, even if they did not like them then or now.

Parental Beliefs About the Nature of Children

In most cultures, parents and other caregivers are more generous and benign in their view of children when they are very small, as infants and toddlers, and in many groups, this view changes considerably once the child becomes a 3- or 4-year-old and even more so after 7 or 8 years of age, when expectations are higher, and discipline is stricter. In many countries, preschool children may start working, be in the field, helping with infants or selling things. Child labor is alive and well in many areas of the world despite the United Nations' declaration of the rights of the child. This is often out of sheer economic necessities of families. Children then are held responsible for things that in high-income countries would be inconceivable, such as selling in the streets, shining shoes, performing tricks in the streets for money or manual labor (Myers 2001). For these children, childhood as we conceive it in the West is very short, as they have obligations from very early on in their life and can hardly have time to play (Goldstein 1998).

In many cultural groups, but not all, infants are thought to be "innocent" and not very intentional in their behavior, as they "do not know" how to behave according to social expectations. In many industrialized countries, like France, Japan, Germany, Italy and many others, couples tend to have less children than a generation ago. As the birth rate has declined, one effect is that every child may be 'planned' and therefore valued intensely as the couple may not have but one more child if so. The attention that the parents can pay to one or two children is different than

when they have six or seven children, as it still occurs in many countries, despite the higher mortality rate. This influences what parents are able to do and teach, and how they raise their children, which may have positive and negative effects (Nishimura 1998).

Additionally, the influence of industrialization, urbanization, and the needs of a capitalistic society have tended to favor a more ‘nuclear’ family model. There is high social mobility, and parents may raise their children in a few cities or countries by the time they are adults. Extended family cannot be the factor deciding where to live as it is in highly interdependent extended family. People do not work for decades in the same company. The “traditional” model of extended family in which there were three generations in one household is not as common as in many low-income countries.

Many parents used to learn their parenting strategies from the advice they would get from elders and from direct observation of the various generations living together. This is disappearing and increasingly, parents resort to books and magazine articles, as well as online advice, on child rearing (Nishimura 1998).

Attitudes Toward Setting Limits and Discipline

Although this is an area where generalizations might be particularly misguided and inadequate, we present some of the literature on differences in parenting styles. This does not apply to any particular family just because they are “Chinese” or “African” or Middle Eastern, etc. Clearly, there will be many differences between people even in the same geographical area, given their life experiences and exposure to different points of view. However, some themes are important to illustrate as they do have an impact on the parenting attitudes toward children.

Traditionally in the Western scientific literature on child development, it is customary to cite Baumrind’s observations (Baumrind 1991) of parenting styles. The author referred to three “types” of parenting, two of which are thought to be negative for children’s development and behavioral outcomes and one “in the middle,” more advisable to adopt in rearing children, at least in the Western world. The two extremes are authoritarian parenting, on one end of the spectrum and “laissez-faire” on the other extreme. In the first, the parent imposes his or her ideas, thoughts, opinions, and orders on the child who has no say on what is going to happen, as the opinion that counts is the parent’s. On the other end of the spectrum, the laissez-faire, the caregiver lets the child do what he or she wants most of the time, with hardly any expectations or consequences. This is thought to be negative as well, because the child does not have any guidance, limits, or containment, and it will be hard for that child to develop boundaries. The authoritative style is in the middle: the parent is in authority, but it is benign, it is fair, and it allows for some flexibility and compassion, for imposing limits without harshness and showing affection in other ways. A further style that has surfaced is the “democratic” parenting style, the parent explains to the child what he or she is doing, why this or that should be done, and obtains the opinion of the child on the subject, allowing for some room to negotiate and take into account the input of the child.

There is a “stereotype” of the extreme authoritarian parenting which has been described in some Chinese mothers, the so called “tiger mothers” (Fu and Markus 2014) which some praise as promoting a higher rate of “success” in children. This is usually defined in terms of academic achievement and accomplishments in general, for instance, in arts and other activities. The general idea of this sort of parenting is what in the West would be considered as a highly controlling style. The child is compelled to do a number of things, even after school, whether he wants to or not, the child’s opinion is not an issue, and if there are protests, these are not taken into account. There is little “wasting of time” and little room for playing or childish activities, the child should be engaged in “productive” activities that will help him or her in the future. The parent is not interested in what his/her son or daughter might or might not like, as the parent “knows best.” Total

compliance is expected. Some children are able to submit to this regime, and some are not, then parent-child conflict emerges. There is a philosophical question as to which is healthier, total submission or "fighting back."

Aside that extreme, there is some evidence that, in general, Chinese immigrant mothers in the United States, compared with Euro-American mothers, are more authoritarian and demand more mature behavior from early on (Wang and Phinney 1998). Authoritarian parenting beliefs are also present in European and Euro-American families, but they are generally considered undesirable by most mental health professionals (Rudy and Grusec 2001). They tend to have a negative effect on the young child internalizing values, and the child acts properly more due to fear of the parent. If the authority figure is not present, the anger and resentment are prone to manifest themselves if the child is not afraid of the person in charge. This cannot be generalized to a more "interdependent" parenting approach in which that style may be considered normative and protective for the child in the long run.

Ideal vs. Real Practices

Spanking is used as a discipline tool for children practically around the world, even though in many countries in Europe (such as Scandinavian countries, and Germany) and other parts of the world, it has been made illegal to spank children (Bussmann 2004; Palmerus and Scarr 1995).

In fact, all forms of physical discipline have been made illegal in about 32 countries, mostly European, but also some in Latin America, like Costa Rica, Honduras, Venezuela, and Uruguay (Global Initiative to End All Corporal Punishment of Children 2010). In contrast, spanking is considered in many countries as a "normal practice" or as a desirable practice in disciplining children, and a distinction is made between spanking and physical abuse.

Nevertheless, physical discipline persists despite the fact that all countries have signed the United Nations Declaration of the Rights of Children (the United States has signed it but not ratified it) (Bitensky 1998). The declaration prohibits degrading, aggressive, and humiliating treatment of children. Countries like the United Kingdom have been criticized by the United Nations because of the application of physical discipline by many parents, which is also widely endorsed by caregivers in the United States, even of preschool children (Holden et al. 1995). In this country, over 90% of parents of preschool children spank them (Straus and Stewart 1999). It is endorsed by parents, teachers, and a significant proportion of physicians (Kazdin and Benjet 2003).

Whether parents theoretically endorse it or not, caregivers in most of the world use spanking regularly as part of their repertoire of discipline. However, spanking of young children is also practiced in many countries, as noted in the United States (Slade and Wissow 2004) and many others. Spanking toddlers and preschool-age children, is also widely used in Canada, the United Kingdom, Australia, and many South East Asian countries (Beazley et al. 2005). Very young infants, in the first year of life, are not entirely protected from spanking, which is practiced by a minority of parents in many countries.

In the United States and other countries, there seems to be correlation between being a "fundamentalist" or very strict Protestant Christian parent and regular use of spanking (Ellison et al. 1996). Conversely, in many cultural groups, younger children are relatively protected from physical discipline as they are considered "too young" or "not knowing any better" to deserve more physical discipline (Firmin and Castle 2008; Vaaler et al. 2008) .

The negative long-term consequences of harsh discipline and maltreatment are very clear and have been demonstrated by multiple studies (Chang et al. 2003). A recent study of spanking in very young children showed a negative impact in terms of aggressive behavior in Caucasian children in the United States (Slade and Wissow 2004).

There is also very little empirical information as to what parents give as a reason for spanking young children. In the United States, a telephone survey with 2068 families found that about a quarter of parents use spanking in children from

19 to 35 months, as well as taking away toys, time outs, yelling, and giving explanations or reasoning. In this survey, African American parents tended to use spanking more frequently. Parental stress, frustration, and emotional instability were factors that predisposed parents to the use of physical discipline (Regalado et al. 2004). In terms of very young children, a study with 1056 mothers in the United States with children between 1 and 5 years of age, found that yelling and spanking predicted a higher rate of behavior problems in those children, compared with "reasoning" or "expectations of the child" parenting styles (Brenner and Fox 1998). In a similar finding, another study with children between 1 and 3 years also in the United States showed an association between more stressed and deprived parents, harsh discipline, hitting, and lower Intellectual Quotient (IQ) in girls later on in childhood (Berlin et al. 2009).

The negative effects for young children in Westernized societies are not restricted to physical discipline (spanking) but to the use of coercion in general as the main ingredient of parental responses toward young children in order to correct or set limits. It seems that scaring the child, becoming emotionally too intense, frightening, and threatening young children into compliance may have negative consequences for emotional regulation in the young child. This also predisposes to development of aggression later on in life (Scaramella and Leve 2004; Baumrind et al. 2010). The process has been called "mutual coercion" between parents and children after the first few years of life, in which the child only responds when the parent becomes emotionally over-aroused, and requires coercion to comply with parental expectations.

Notwithstanding all this evidence, coercive parenting practices, like spanking are still practiced in most of the world, not only as a matter of culture and pragmatism, but even from a religious perspective. In the United States the most conservative protestant movement on parenting advocates, based on statements from the Bible, spanking and physical discipline as desirable and necessary to deal with children (Bartkowski and Wilcox 2000). One of the core beliefs is that children are naturally inclined to do bad things (Mercer 2004), and they need to be corrected from very early on. In sharp contrast with previous surveys, a recent one from the Pew Research center (Pew Research Center 2015) indicated that parents tend to use less spanking than it was previously found. Again, these are not "practices," but what a parent says they do.

In this survey, a sixth of parents say they spank their child sometimes. The most popular strategy, used by 75% of parents, was "explaining" why the behavior is undesirable. About 43% take away "privileges," such as time with friends, television, and electronic devices. A similar proportion gives "time outs" to children under six, a fifth indicate that they yell. Only 4% of parents say they spank the child often. But a sixth do it sometimes. In general, the more educated the parent, the less they use spanking as a disciplinary strategy.

Harsh discipline and physical punishment are widely practiced, even when the ideology of people in a certain culture does not endorse these practices. In two surveys in India, high frequencies of physical and harsh discipline have been found, in nearly 60% of parents (Segal 1992; Hunter et al. 2000). In most of Latin America parents tend to say they "should not" hit children but resort to physical punishment because they lose their patience, so in practice spanking is also widely used, as well as other forms of harsh parenting (Frias-Armenta and McCloskey 1998).

On the question of who to turn to for parenting advice, the Pew survey offers some glimpses of what parents do in the United States. Fifty-seven percent of parents turn to their spouse for advice most of the time, equal for fathers and mothers. There is the little interest in going to other relatives for advice, only 27% of parents say they would ask a family member. Friends are reported by 15% of parents. As to parenting books, they seem to be of little value in the mind of parents: 7% of parents turn to parenting websites or books/magazines for advice, which are more often used by the more educated parents. Also, those with younger children do use those outlets to get the "best", latest, or more scientific recommendations.

The presence of an extended family in the household or nearby might have a protective effect against harsh discipline and the possibility of child abuse, as other family members may take over when a parent is about to lose his or her patience. On the other hand, this also means that more people have "disciplinary rights" toward children, like uncles, aunts, older cousins, etc. the practices might be very discordant and vary widely. In many cultures, it is normative for older siblings to contribute regularly to the discipline of younger ones, mostly through admonitions but at times through hitting.

Discipline and Gender

In many cultural groups, there seems to be different expectations of behavior and compliance, as well as consequences for transgressions depending on whether the child is a boy or a girl. This is related to the particular beliefs about the fragility of girls, the need to make boys stronger or tough, and the severity of the misbehavior. In many cultures, boys are punished more and more severely than girls. A recent study in the Philippines (Sanapo and Nakamura 2011) found this, and that mothers were the most frequent enforcer, by means of pinching and beating the boys. This is in sharp contrast with cultures that value boys much more than girls, in which girls have an inferior social standing, greater expectations placed on them for obedience and are treated much more harshly than boys (Hunter et al. 2000). Of course, a simplification is impossible because in some families the high expectations of boys may explain harsher punishments also, in order to enforce such high standards.

The gender issue also applies to "who" carries out the discipline of children, if it is a shared endeavor. Most discipline is enforced by the mother who in many societies is more in charge of the parenting (Sanapo and Nakamura 2011). In the past in Westernized societies, children might be told by their mother: "wait until father comes home" to give the father the task of applying the discipline (Kerr et al. 2004). The role of the mother and father as disciplinarian may vary in different cultures. A small study comparing Italian, French, and German parents observing children and fathers in the playground found that the fathers in the first two sites were more affectionate and played more with their young children than the mothers, while the opposite was the case in the German site (Best et al. 1994).

Child Characteristics

The cultural ideas about how a boy or a girl "should be" determine the nature of the encounter, or clash, between parental (or other relatives) expectations and the "infractions" committed by young children, particularly those of preschool age. In many cultures, girls should always be pleasant, obedient, docile and subservient, even in Westernized societies. They have to smile and hide their feelings, particularly if they are filled with anger or unhappiness. Boys may be encouraged to be brave, to fight if necessary, and to respect hierarchies in very paternalistic societies. If a boy is sensitive and shies away from conflicts or fights, he might be chastised as a coward or mocked and ridiculed in order to "make him tough." Also, if girls are intense, bold, and argumentative, this may be seen as a very dangerous trait that should be extinguished systematically through disciplinary maneuvers.

Other Disciplinary Strategies

As an alternative to hitting, quite harsh disciplinary strategies are implemented by parents all over the world, such as standing on a corner, having the "nose to the wall," kneeling on a rough surface, holding bricks for an extended period of time or assuming and uncomfortable posture for a specified time. Others are threats they do not mean to carry out but just frighten the child, such as warning to burn hands, and other threats of severe bodily harm. Parents in some areas of Mexico, India, or many other countries might put chili pepper in the mouth of a child.

In addition, and at times instead of physical discipline, there are verbal admonitions and

shaming the son or daughter. Parents in many cultures use other techniques based on instilling fear or guilt in the very young child, and of course, older children. Even 2- to 3-year-old children may already worry that they "might be bad." The strategies include telling the child he is bad, a bad person, a bad child, etc. Also, young children may experience a lot of guilt for past transgressions, inspired by their parents. Other techniques, very commonly used in Latin America and many other countries like India, consist of scaring the child with various negative outcomes such as leaving the child behind if he or she does not want to leave a place, "giving the child away" to a stranger, calling the police, or telling on the child to a policeman. Also, the child may be threatened with consequences like apparition of witches, evil spirits (Hunter et al. 2000), ghosts, or the devil. These are very realistic possibilities for the magical thinking of a young child who may think literally that such things are possible. It is an open question whether these strategies are related to later outcomes such as anxiety disorders or depressive conditions.

In some parts of the world, even children of preschool-age are expected to behave in such a way as to preserve the honor of the family and not bring shame to their parents. From a study in a rural village in Iran (Friedl 1997), a researcher found multiple examples of high expectations. Girls are expected to be obedient, cast their eyes down when spoken to, never look at men, particularly if they are strangers and mostly stay inside the house and never "talk back." Most children are expected to be shy, particularly girls, and never to show pride, which is a sin. Many of the family's actions are directed to save face and preserve their prestige. A mother might reproach her young child: "You make me lose my honor," as losing face or honor is a constant danger.

Discipline and setting limits are highly charged subjects, and the beliefs are strongly influenced by childhood experiences, but also strongly shaped by the prevailing beliefs and Zeitgeist, despite important efforts to eliminate violence between adults and of parents toward children, much work remains to be done in terms of research and influencing parental beliefs.

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17 Cultural Issues in Response to Young Children's Illnesses, Chronic Conditions, Malformations, and Their Management

Andrés Jiménez-Gómez

Issues Related to Pregnancy

In previous generations, there was a great deal of uncertainty as the outcome of a pregnancy, and also about the condition of the baby in utero, starting with not knowing the gender, and then regarding the health status of the baby to be born. In many countries, with the advancement of technologies, disciplines like perinatology and maternal fetal medicine physicians are able to diagnose a number of health complications or alterations that may or may not be compatible with a "good outcome." Parents are faced with adverse health information much earlier than in previous generations, and at times with having to make decisions about whether an amniocentesis (Browner et al. 1999) or other procedures should be conducted to definitely diagnose a certain disturbance. They may face options like whether to continue with a pregnancy, and even about whether there should be surgery while the baby is inside the womb in order to correct some malformations. These decisions have a strongly cultural component and this issue would need to be taken into account in a health care system responsive to the needs of various groups.

A common contrast between cultural beliefs can be seen for instance when certain "bad news" are discovered, and "who should know" about such news. In the United States, it is a standard practice to tell adult or child patients that they have cancer, as it is thought they are entitled to "the truth" for multiple reasons, and patients themselves are assumed to want to know. In many cultures around the world, in the same situations, the patient is not told of an ominous diagnosis like that, and much less if it is terminal or if metastases have been discovered. Among other reasons, people fear the patient would get discouraged, lose hope, or be devastated on learning that news. In the United States and other countries, children are routinely informed about very severe diagnoses and their parents usually agree to this disclosure. In Mexico, Japan, and many other non-Westernized countries, parents would not want their child to learn of a severe diagnosis, among the reasons mentioned above because they could not make decisions about treatment.

In a similar fashion, not all parents might want to be told that their baby in utero has a major malformation, a severe syndromic condition, or that the baby is "expected to die" in utero or a short time after birth. Parents who belong to various cultures might resent such bad news, and may in fact not believe them, despite chemical evidence, images, and the like. If in one's world view "anything can happen" if it is God's will, even the scientific revelations of doctors might be put into question. We have encountered parents of Mexican or African origin who say that when

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they were advised of bad news during the pregnancy, and despite having been told the baby would die, they were hoping for a miracle to be bestowed by God and up until the last minute, they were hopeful that something different might happen, and only are faced with the reality until they see for themselves the baby once he or she is born.

One of the questions in the face of different attitudes toward ominous conditions is whether hospitals should have a "one policy" to be applied to everyone regarding a bad prognosis or whether at least their beliefs that the scientific evidence "could be wrong."

One further angle in connection with "not believing" or "not wanting to know" terrible news is what can be considered as a "healthy denial" or not losing hope. Many families in Latin America and of Mediterranean origin believe that "hope is what dies last" and therefore acting as though the bad news did not really register is an important coping device, then they have to face things as they happen, not before. Well-intentioned personnel from various medical centers in urban hospitals from modern cultures might worry that some families "do not really comprehend" or "do not realize" the seriousness of a disease or a fateful prognosis and see that as a sign of a pathological coping strategy. This is an open question: within different cultural worldviews, alternative coping strategies might be understandable. The quality of the doctor–patient or doctor–family relationship in different cultures is a determinant issue as well. In many traditional cultures, the doctor "gives orders" or "makes prescriptions" and the parents' opinions are not as determinant as it might be in a more "customer-oriented" society. The doctor may be seen as an authority figure, who decides what is to be done and prescribes a course of action. Parents from a non-Western culture who are immigrants in an industrialized country may see their clinician in that fashion, and feel that if the doctor recommends something, they really should not question the doctor, and even if they disagree with a procedure or course of action, they may not wish to offend the doctor, and agree to recommendations even if they really do not agree with it. The clinician in these cases may want to give time to the family to reflect, if possible, and to encourage them give their "true opinion" openly.

A further matter is to consider the parents' health care decisions from a cultural lens. To give one example, Mexican mothers in the United States who are offered an amniocentesis (after a high level of alpha-fetoprotein has been detected in the mother) tend to decline the procedure more often than other mothers (Browner et al. 1999). Alpha-fetoprotein is associated with a much higher risk of malformations in general, and trisomy 21 and spina bifida in particular.

Even among Caucasian and African American parents, if they have religious beliefs against abortion, they may not necessarily "want to know" or to have to make a decision regarding continuation or termination of the pregnancy in the case of conditions like Down syndrome.

A related issue is the "genetic counseling" that nowadays is non-directive in most hospitals in industrialized countries. A family may hear the statistical figures about the risk of having another child with autism, or with a certain syndrome after having had a previous child with such condition, and despite a high risk involvement, they may indeed go on to have another child despite a high risk of repetition of the illness. This may be rooted in the belief—which has a higher priority than the scientific advice—that each pregnancy is determined by the will of God and therefore He decides what the new child will be like. The parents may well accept another child with the same syndrome as tests that God gives to that particular family for unfathomable reasons. The same occurs with some very profoundly Christian families in Westernized societies.

There are also cultural factors as to "which conditions" or alterations are considered more ominous or unbearable. For instance, if blindness, deafness, a brain malformation, etc. are announced, they may be more or less acceptable or terrible for parents, who base their decisions on the perceptions of the quality of life their baby would have, and the social stigma associated with

it, the availability of services for such a child, and the likelihood of leading a happy life in the future.

There are crucial cultural implications in what it means and what are the consequences for the child and the family, if a son or daughter has major handicaps or malformations in highly technological societies in contrast to conditions of rural poverty in a non-industrialized country. Having a child who chronically requires a respirator, who needs oxygen for a long term, or has a tracheostomy, who may require physical therapy due to cerebral palsy, or who is blind or deaf, all of those situations represent different challenges for a family in one condition or another. Parents who live in precarious circumstances may feel forced to make difficult decisions because of the sheer number of stressors they are already facing and because they might not be able to afford all the services the child wound need. Also, the needs of their other children may have to be taken into account.

In certain situations, parents also may face conflicting advice or "diagnoses" from the medical establishment, which may disagree with the prophecies or opinions of a fortune-teller, a psychic, a witch-doctor or other folk healers who may give a different prescription than the one offered at a hospital. Who should one believe? There is some suggestion that in urban Western hospital centers, parents who are perceived as less educated or less receptive, may not even be offered some prenatal diagnostic procedures; this was a finding in a study involving South Asian parents (Rowea et al. 2004). In some centers, pregnant Muslim women might be viewed stereotypically as "not wanting" prenatal testing in any circumstance. In reality, from an Islamic point of view, a termination of pregnancy is permissible if it is carried before a certain number of weeks, as in Pakistan (Ahmed et al. 2000). This involves the issue of "ensoulment" of the baby in uterus, that is, the time at which the fetus is considered to have a soul, which occurs around after the 120th day (Al-Matary and Ali 2014). Of course, official religious sanction may or may not agree with cultural traditions in different regions.

The Infant with Chronic and Other Health Conditions

The birth of a child with major health problems, such as a malformation, a chronic illness, or who is extremely premature provokes a number of reactions in the parents and the extended family. The responses may vary from a feeling of rejection and horror, to one of estrangement and thinking that the child is "too different," or to a complete acceptance of the child the way "he or she is" as well as many other emotions. When the condition is grave and requires special care and multiple or costly treatments, this adds further stress to the parents/extended family; moreover, the child may require repeated hospitalizations, surgeries, and complicated treatments which may be financially prohibitive for many families and drain their emotional and financial resources.

In such conditions, it is only natural that people from different backgrounds look for multiple possible explanations as to why the child has these difficulties and what should be done to help. There are historically a great number of traditions and beliefs, many of which have been disappearing with the progress of science. However, the basic issue of how one reacts to the birth of a "different" child, someone strange or unusual, is still a part of the human psyche, which is reflected clearly in the myths, traditions, and practices of many cultures. Nonetheless, even in the most industrialized countries and modern societies, there are similar reactions to the birth of a "different" child, even if no transcendental, supranatural, or magical beliefs are invoked.

Historically, when a child was born with a severe medical condition, the more severe or deforming the condition was, the more ominous the meaning for the family and the surrounding society. At times, these children were left to die or actually killed in some way. Often, the diagnosis of the problem was left to diviners, shamans, or religious figures, who gave the final judgment as to the nature of the condition dictated what was to be the fate of the child.

In many European cultures, as in many other parts of the world, infanticide of those born with significant malformations was commonplace.

This is said to have been a common practice in Sparta and others in which a child that had such a poor outlook was left to die through selective neglect (Scheper-Hughes 1990).

One of the most common responses to the birth of a child with a severe disease or unusual somatic features is a feeling that something went wrong from external sources, another is that the child represents a punishment for a transgression or an omission, or that the child might even be a message from higher beings such as ancestors or gods. These theories also apply in cases in which a child has unusual or difficult behavior, not just odd bodily features. The main groups of causal explanations could be described as: (1) the untoward emotional state of the mother during pregnancy which can have a negative effect on the baby. (2) A transgression or a sin by the mother, her husband, or a close member of the family, may lead to a punishment that impacts the baby. (3) The child has been changed, and instead of the normal child, there is now lying there an unusual baby who really belongs to another world, or has a different nature, such as fairies, demons, or spirits. (4) The child is the product of an unnatural liaison between the mother and an evil spirit, a fact of which she may or not be conscious. The child is a "mix" or a "hybrid" of human and nonhuman, a product of unwitting or willing intercourse with a fairy, a spirit, a *djinn*, or a wondering spirit. (5) The child is seen as born with problems as a result of God's will. In many traditional groups, it is thought that one's life course, events, and outcome are written at birth (in Arabic, *maktub* = written) in the person's life book, which may represent also a test of one's faith to be accepted and endured without question. (6) In "scientific" explanations (such as genetic disturbances, effect of natural causes in utero, etc.) the condition does not have to consist of physically visible malformations but can be invoked in the case of difficult behavior in the baby or small child.

A further consideration for parents is the cultural group's acceptance of children (and families) with disabilities. While in some social groups it is quite acceptable to take children outside, to a child care center or other public places where there may exist numerous accommodations for them, in others, there is much a stigma of having a "defective" child.

A Japanese family seen by us recently, had a preschool child with autistic disorder who slapped himself repeatedly on the head, and had to wear a helmet in order to prevent serious lesions to his head. The parents were immigrants into the United States. They appreciated all the services the child could receive (language, occupational, physical and behavioral therapies) but they dreaded to take him outside or to a park even. They were very worried about the impact that seeing a child "like their son" might have on other people. Seeing a young child hitting himself might feel onlookers feel uncomfortable and they tended to keep him inside the house as much as possible. They were not ashamed of him, but feared that others might be offended by looking at him, as it might have been the case in their country.

Parents, of course, generally wish their baby to be healthy, and if possible, beautiful. In many modern countries, there is now the expectation that the child should be perfect physically. An author has suggested that in the "new culture" in Israel, for example, there is a strong admiration for perfect, strong muscular bodies, and disabilities are considered almost unacceptable, at least from the emotional point of view (Weiss 2007). With globalization, the phenomenon may be more pervasive in various social groups that increasingly identify with "strong bodies" and "perfection" and are intolerant of "defects" in people, male and female.

We illustrate some of the above explanations with a few common beliefs in various parts of the world.

In rural Ireland, until recently, among some families, there was the belief that a newborn could be taken away by fairies or other supernatural beings, such as elves, wood spirits, underground beings and other non-human creatures (this was also true in Eastern Europe). These entities desire a beautiful child and take away such baby, and leave in place of the human, one of their own instead, that is, the good and perfect child is changed for a "defective one," therefore,

the notion of changeling (Zhang 2013). An anthropological study found that this belief accounted as an explanation for children who behaved oddly, cried too much, or had a malformation. This is a traditional belief also in some areas of Germany where the term *wechselbalg*, and in Dutch *wisselkind*. Other signs are a large head, an odd facial appearance, and excessive crying in the baby.

In folklore, it has been described in Switzerland that children who had mental retardation due to "cretinism" were of good luck, because such son or daughter is like a repository of God's anger, which therefore is focused only on that child and thus spares the rest of the community or village (Eberly 1988).

One could say that often, below the surface conscious beliefs about the natural causes of illnesses and malformations, there is frequently a measure of guilt in parents, a suspicion that they might have done something wrong to bring about the negative outcome, or the fear that they somehow are under the influence of powers they cannot comprehend or control. However, at the conscious level, an external cause is a sort of protection, the child kidnapped by a fairy and taken away, while she left the "wrong child" on the crib, protects the family from any feelings of guilt.

An infant with hydrocephaly could be considered as a changeling due to the large head. One that cried excessively also revealed thus its "obstinate nature." If the child shows developmental delays, and does not move much and later on does not talk, this may be judged as evidence of the unnatural origin of the baby.

The Infant as a "Hybrid" of Mixed Being

In many societies, the birth of an infant with some sort of malformation was thought to be a "sign" of something, it could be ominous, frequently, or occasionally, a sign of good luck. Some characteristics such as webbed feet, or a peculiar facial structure, or a scaly skin (*ichtyosis)* often were considered as signs of the "hybrid" origin of the baby. The child would be the product of a relationship between a mother and an alien or supernatural being, who could not be seen, but whose presence is testified by the birth of the "mixed" child. The union between the mother and the supernatural being is often unknown to the mother, and the causality only assigned after the birth.

In the traditional British culture and in many others, there were beliefs that humans could cohabitate, often unwittingly, with supernatural beings and then a "hybrid" being would be produced. In Greek mythology, this often gave as a product, a semi-God with superior capacities or powers. In the British Isles, particularly in the coasts, it was thought that humans might cohabitate with mermaids and produce hybrid beings. Similar folk beliefs were also common in the Scandinavian countries. The mermaids were usually thought to be beautiful, while the masculine fish-like fairies were thought to be ugly, but they also could have intercourse with human women. In old times, children who were born with fusion of the legs (*syryngomelos*) were believed to be a product of such unions. A similar explanation could be invoked if the baby had "scaly" skin, or had webbed fingers or webbed toes (syndactyly). In the folklore of Scotland, it was thought possible for seals to have unions with humans, giving birth to children with similar malformations to the ones described above. Anencephaly was thought to be the "head similar to that of a seal."

In Scandinavian folklore, there were accounts of "trough backed women" called *ellewomen* (Briggs 1976), who were beautiful, and could correspond to disorders of the closure of the neural tube (rachischisis) in the spinal area.

Cretinism, a form of early hypothyroidism which, if untreated, leads to intellectual handicap and poor growth, used to be endemic in regions where iodine was not available in people's diet, such as some parts of Switzerland and Franconia, Germany (Persing et al. 1989). It used to be ascribed to the Devil impregnating maidens. It is said that Martin Luther advised the prince of Anhalt to drown a child like that in the local river, as it was only a "piece of flesh with the soul of the Devil."

Beauty, Malformations, and the Perception of the Baby

Malformations, particularly when they are severe, confront parents directly with the challenge of having a child who not only may not be "attractive" but may elicit contradictory feelings. It is natural for parents to have multiple and conflicting reactions to cleft lip or palate, a missing a finger or to have an extra one, or indeed or any other major morphological problem, from empathy toward the baby, to anger, worry about the future of the child and uncertainty as to what is going to happen. In modern societies, genetic testing may be available to diagnose and treat these conditions. However, we find that in the mind of many parents, despite all the scientific underpinnings and explanations, there is often the doubt as to whether they did "something wrong" or violated a hygienic precaution to have caused or contribute the condition in the child which might be "their fault" or a sign of such transgression.

In many cultures, there is an "externalizing explanation" for such a condition, particularly if it is severe, and the explanation may provide some relief to parents and relatives, for instance, if an evil spirit penetrated in the child and caused the malformation. In the case of Abiku (Ilechukwu 1990), a condition often diagnosed in families in Nigeria, the child with a malformation can be thought to bear the "marks" of a spirit that was mutilated in a previous life and now has reincarnated in this new body, carrying the scars or mutilations of previous maltreatment. In other cultures, like in various areas of India, a child with cleft lip may be ostracized by other children or adults, even by neighbors, who may avoid such a child, as the young person is thought to bear the mark of some transgression or impurity on the part of the family, that is, the malformation is a "punishment" for some misdeed, which makes the child and his or her family different from everyone else, and unacceptable. The family may themselves have that belief and the child in question grows as though he or she were the bearer of such shame. Many of these reactions and beliefs still apply in many areas of the world and in Westernized cultures as well, even though at a less conscious level.

If there is a perception of the family somehow being "at fault" when a child with a dysmorphic condition is born, the social reaction may also include ostracism of the child and/or family. Others around them may fear that the affected family might invite negative influences to occur also in a village or geographical area and it would be better if the family vanished or disappeared.

An additional complication may be the reactions of the extended family. On occasion, the families of origin of the child's father or mother, who have made a matrimonial contract "between families" start to argue or blame each other for having carried some kind of "hereditary taint," or from being of a bad stock, or for possible representations that the malformation is the result of being part of a bad family. The spouses also can blame each other, or one spouse blame the other as having caused the problem due to behavior or lifestyle issues.

A family treated by us, originally from China came for treatment, they had a set of twins with a chromosomal disorder that led the twins to develop developmental delay, cerebral palsy, and difficulties with sleep and disruptive behavior. In the course of treatment, much marital discord arose to the surface. One part of this was the mother's view that her mother-in-law had blamed her for "not being able to bear healthy children." Indeed, the mother-in-law had told the babies' mother that she should "throw herself from a building with her two useless kids." The children's mother was very offended because her husband did not defend her at the time, instead he acted deferentially toward his mother. His argument was that his mother "did not mean that" but only had said something in anger, and his wife should not be offended. This impasse had lasted about 12 years.

Among members of a tribe in Benin, the Bariba, witches are thought to be present at the birth of children. They can influence a negative outcome or cause the appearance of odd features, such as a breech presentation, a baby born with teeth, or with more fingers than normal (polydactyly), which indicates the evil influence in the child, who has been "born to die" (Sargent 1988).

The diseases of children with obvious malformations used to receive descriptive or mythical

names such as "mongolism" or "moronism," and the child described with names such as cripple and spastic. which now are unacceptable in Westernized societies. Not many years ago, many syndromes still had such names such as "gargoylism," that is, the child looking like a gargoyle, which was given to the various mucopolysaccharidosis syndromes (Hunter, Hurler, Sanfilippo, Morquio syndromes).

Conditions like hydrocephalus, Cornelia de Lange syndrome, Kabuki syndrome, and many others challenge strongly the view of the "beauty" of babies, and force parents and relatives to "make room" in their minds to the baby they have in front of them and who may be quite shocking at first, and only gradually they may get used to the "new normal." In England and the US, not many decades ago, it was customary to "institutionalize" children who had major handicaps and malformations, keeping them away from the family, in part because of their needs, but also due to issues of social stigma, shame. These segregated children were hardly ever talked about or discussed in public.

It is also well documented that in the name of "Eugenics" the Nazi ideology in the 20s and 30s of the XX century advocated (and in many cases carried out) the "euthanasia," that is, the killing of children with handicaps as they had "lives not worth living." In many other countries, there were groups that feared the reproduction of "defective" human beings also in the name of preserving a "good genetic pool" and for decades the forced sterilization of many people was carried out in a routine manner in institutions for adults with mental and intellectual handicaps. These are events of the recent past, but they illustrate the challenge that it may represent for parents and societies to deal with children who have major medical conditions or malformations.

Several anthropologists have discussed the fact that in many traditional societies, the practice of "selective neglect" of children who have major malformations or diseases is still carried out. In most circumstances, this is related to the poverty of the family, the scarcity of resources, the enormous need of medical care of a child in social groups without supportive structures to provide such care, and the need to look after the other children (Scheper-Hughes 1990). It is important to understand that in some of these cases, the families may see as their only option to practice some form of infanticide, for instance, if the newborn is thought to be a "witch baby." As mentioned, among some Bariba in Benin (Scheper-Hughes 1990), the diagnosis of the baby being a witch may depend on physical signs and malformations, and even on whether the upper teeth appear before the lower (mandibular) ones which may be interpreted as the baby having its origin in the underworld.

Infanticide has been practiced all over the world for centuries, and in part this depended on the question on whether the child is considered as being "a person," in the first place, as in some of the scenarios already described. At times, a selective neglect of the baby is practiced, and if the baby is very small, weak, does not eat well, or shows signs of illness, the parents may interpret that the child "does not want to live." This obviously brings up many ethical dilemmas, but it is important to understand that from such frame of mind, the baby is assumed to not belong in this world, or it is thought he or she represents something dangerous and taboo. The baby may be thought to be an "embodied spirit" and if the spirit returns to its world, he or she will be more comfortable.

In the West, the dilemma of "personhood" is often seen on the question of abortion (when a baby in utero is already "a person."). It could be at conception, after the 12th week, the 20th week of gestation, or at birth. In many cultures, a recently born baby may not really be a person until a certain ritual is practiced to "admit" the child into a family or group. Infanticide was until recently more common in India and China. In India, because of the burdens of having girls and having to save money to pay for a dowry years later when the girl had to be married off; in China, because of the (now revoked) policy of "one child only" per family, paired with a parental preference to have a boy who may be able to take care of them when they become old.

Western health workers in some of the areas where these practices exist may try to intervene

to prevent these killings, or come for a period of time to perform a specific corrective surgery, for instance, to correct cleft lip or palate. Even if for the Western mind the "defect" has been repaired, this does not necessarily erase or alleviate the "internal nature" of the child, who may be a spirit, or a witch in essence still, and may continue to be stigmatized, together with the family. The child can be the repository of the blame for all the bad things that may happen to a family or a community and may be perceived to have evil powers. Several anthropologists have cautioned against the assumption that the mere reparation of a certain defect in a concrete way means that the child's life is going to have a much better quality of life from then on, but more interventions may be necessary after the surgery to help the child "reenter" social acceptability in the long term.

In most countries where this has been studied, there is a higher risk of maltreatment and neglect in children with major deformities, chronic illnesses, or those who demand a lot of attention from their parents, such as the ones who have excessive and persistent crying or chronic illnesses (Stalker and McArthur 2012). The reaction of parents and other relatives to the birth of a child with a serious condition that will lead to a motor handicap, or who suffers some sort of accident that leaves the child in that condition, have primarily an individual dimension. Each person has their own reactions as a mother, father, sibling, etc. to the birth of a child with such conditions. There is, however, also a cultural realm.

A researcher in Algeria (Kouadria 2000) described common reactions: the pattern of guilt and overprotection on the part of the mother, the intense devotion of the mother to the care of the baby and her anxiety about the child's future. But there is also an experience of shame as exemplified by several words in the local lingo which describe the handicaps with negative connotations, such as "*mahboul*" crazy, *meskoun* (possessed), *meshour* (bewitched) or *aieb* (crippled). Faced with the condition, the parents have to deal both with the "medical explanations" and treatments, as well as the traditional ones, such as the influence of djins (evil spirits or angels) which, to be placated, require the intervention of a healer (*taleb*). In the West, there is less "shame" for the child and the family, but in many traditional societies the child is kept from the sight of others or from going out in public for fear that people might look down and consider him or her as inferior or feel sorry for the child and the family.

Cleft Lip and/or Palate

In many cultures, there are strong beliefs in the supernatural, magical and magic regarding the etiology of cleft lip or palate. This is changing in most of the world, as parents are increasingly aware of the biological phenomena associated with these problems. However, there is still a widespread belief in supernatural etiologies (Black et al. 2009). A recent study in Nigeria among the Hausa and the Yoruba in rural Nigeria found that a majority of parents attribute cleft lip or palate to "ancestor spirits," other evil spirits, or "the will of God." A great proportion of families with an affected child had consulted local folk healers before going to the hospital or for treatment with modern medicine (Olasoji et al. 2007). In some groups in Mexico, the problem is often attributed to the mother of the child having been exposed to an eclipse during the pregnancy, or to alcohol consumption by the father. In many cultures, there is the belief that if a pregnant woman is frightened by a rabbit, the baby can acquire the trait, which also can occur if she laughs or makes fun of someone with a malformation.

Dwarfism

In North America and Europe, people with "dwarfism" (individuals with these conditions often prefer to call themselves little people or of short stature as the term dwarfism has a pejorative connotation) have historically been portrayed in movies and stories as amusing, mischievous, entertaining, or ridiculous. A recent study of attitudes of college students regarding the stereotypes and cultural perceptions of people with "dwarfism" (Heider et al. 2013) found that common

opinions of the stereotype were "weird," "amusing," and quick tempered. Other beliefs were more positive, such as "intelligent," "capable," and the like. Some responders reported feeling pity and compassion for such a person and thought that people with the condition often appear childlike. In many countries, people with unusual body features were at times employed as a part of exhibitions, such as the "freak shows" in Britain and the United States (McHold 2008). These spectacles could include people with dwarfism and other conditions such as gigantism, morbid obesity ("fat people"), and women with hirsutism among many others. The meaning of these spectacles is multifaceted, but one aspect is the general anxiety and fear of "being like them" and the comfort people may experience in segregating them and seeing these persons as "not me" or as "the other." In some of these folk "displays," people with deformities would verbalize that their condition was due to "disobeying their parents" or due to greed, intemperance, or a punishment from God. It appears that socially there was both an anxiety, fear, and at the same time a fascination with the "oddity in the other." Also, those explanations as the condition being a punishment for misdeeds were meant as a warning for children not to commit social transgressions lest they be punished in the same fashion.

In some aboriginal cultures of the American continent, like the Mayans, and Moche (Rodriguez et al. 2012) individuals with achondroplastic dwarfism were considered as "liminal beings," that is, in the border between this and the other word, or a mixture of the human and the divine and were thought to have great power. They often worked in the arts, playing music and assisted in governmental functions.

Asthma and Other Respiratory Diseases

In urban centers, (Smith et al. 2005) asthma is a medical condition which has an important ethnic/cultural/social determination, as it concentrates among the poorest children, who live in conditions of humidity, infestation with cockroaches, and pervasive smoking in the small dwelling units, with the worst housing (Rosenbaum 2008). Asthma is more prevalent in ethnic minorities in many urban centers (Forno and Celedon 2009). A cultural element described in some Asian families (Smeeton et al. 2007) is the belief that the drugs used in the treatment of asthma could be addictive and do more harm than good. In a small study in England, parents from India and Pakistan also tend to use preventive measures less, and as a result the children may have more hospital visits compared with other ethnic groups. Some communities use dietary restrictions to deal with the asthma, for instance, among Bangladeshi mothers, a precaution to avoid asthma is restricting foods like banana and others that "irritate the throat" (Cane et al. 2001) and asthma can be considered to be contagious. In traditional cultures, the remedies for asthma, learned from older generations, may include rubbing wax on the chest, and drinking infusions, such as of lemon and honey. Many parents may see asthma not as a chronic disease, which requires constant treatment, but only as an episodic event (Van Dellen et al. 2008).

Ambiguous Genitalia

After the birth of a child, one of the first questions asked is of the health of the baby and the mother, and immediately after what the gender of the baby is, a boy or a girl. This may be a difficult question to answer if the newborn has ambiguous genitalia. Obviously this situation, being born "hermaphrodite" or "intersex" or with ambiguous genitals is very difficult for parents, as there often is intense emotion and investment in the gender of the child. There are then dilemmas such as whether the child "should" be raised, as a boy or as a girl, and questions about the reproductive capacity of the child later on. With such intense emotional investment, it is common for parents to feel confused, baffled, and anguished, when the medical staff says that there is a need for further studies. It may be difficult for the parents to actually see the genitals of the baby, which may include a "micro-penis"

or clitoris, and the presence or absence of testicles in what appears to be labia, etc. This state, ambiguous genitalia, also has a strong cultural representation. In many societies, historically, the decision as to what gender to assign the child, has been left to the physicians, who with the best intentions may make medical and surgical recommendations, such as clitoridectomy, reconstruction of a vagina, etc. the medical team then may recommend to raise the child as a boy or a girl. There are multiple reports of this approach being misguided, as the child him or herself may be dissatisfied years later with the decision, and even more so as an adult (Lee and Houk 2010).

In a study in Saudi Arabia (Abdullah et al. 1991), there were a number of complicating issues: the need to consult religious leaders as to what Islamic law permits, what is their opinion, and then the wishes and opinions of the parents. Additionally, parents had a bias toward having a "boy" and even the staff may feel pressured to say "it is a boy" (it is customary for the parents to bring a gift to the doctor or nurse in the hospital if the baby is a boy). Also, there is the issue of consanguinity, like marriage between cousins, which is a common practice, and this makes conditions like congenital adrenal hyperplasia more common. Some parents were angry when they were told that, after all, the baby was not a boy. There are worries about the correction of the female genitals, due to the concern with the preservation of the hymen, which required doctors to issue a certificate explaining why the hymen was not intact, a very important concern. Also, grandparents often had the "last say" in the decision to assign the baby, rather than the parents. The doctors resorted in some cases to "not telling everything" to the parents so they would accept what was best for the child. Additionally, parents expect to conduct a "naming ceremony" within 7–14 days after the birth, which the extended family expects. Delaying this event in order to conduct hormonal and genetic tests represents a major complication for parents. Clearly, there are multiple and overlapping considerations as well as ideological/cultural and religious factors that need to be taken into account, and not purely the "medical ones."

Other issues in the decision are the increased risk of developing malignancies in some of these conditions as well as "salt wasting," that is, losing sodium through the urine due to hormonal imbalance. The pressure to bias the decision toward a boy is also noticed in China, India, Pakistan, and the Middle East in general (Warne and Raza 2008); for economic reasons, the boy is more likely to be economically independent and to be of support to his parents in old age. Also, a girl who is sterile, as many of these children may turn out to be, would be more difficult to marriage, she may eventually attract a stigma because of this and the parents may have difficulty in arranging a marriage. Another concern is the "privacy" one. If a child has ambiguous genitalia, this may be difficult to conceal as the child is likely to take baths and showers with relatives, including cousins.

An additional issue in the diagnosis and treatment of these states is that in many poor countries, there is no infrastructure for laboratory tests, imaging studies, genetic assays, nor for hormonal treatment or even the various surgeries that might be needed, and this may expose the infant later on to ridicule or ostracism.

Nowadays, there are many clinicians and anthropologists in the Western world who advocate to abandon the dichotomy male–female (Fausto-Sterling 2000a), and to adopt a more flexible approach along a continuum of identities and possibilities (Fausto-Sterling 2000b; Kessler 1998). This would mean to separate in one's mind what the "genitals look like," what the person feels and thinks he or she is, man, female, both, or some degree of each, and to whom the person is attracted to sexually or in terms of stable partnerships. The permutations are multiple.

In some cultures, there are conceptions that approach the notion of a "third sex" or "neither man or woman," for instance, *hijra* (hermaphrodite or eunuch, in literal translation from Hindi) in India. The approximate definition is a group of people who live together or in a community and are neither male nor female, it may include a variety of people really (from transvestites, to homosexual, to transgender, and truly hermaphrodite persons). They are however, rather ostracized,

somewhat discriminated or "tolerated" groups, who often survive by singing at weddings and other festivities, or begging. In India, most parents would be scared if told their child would become a *hijra*.

In Samoa, there is a term *fa'afafine*, which is not as shameful and allows a man to "live like a female," but technically the person is neither male or female and is a "third gender" and the person is thought to embrace both "masculine and feminine qualities." In some cases, the assigned gender relates to the parents "deciding" that a boy should be raised as a girl, because of the wish for a girl and to help her in domestic work. In other cases, it is thought that the boy has a "feminine spirit" and therefore is not considered gay, as the actual genitals are thought to be of secondary importance. In older times in Hawaii, also it was recognized that some children were not either male or female.

Modern Societies and Technological Advances

In technologically advanced societies and among the wealthier classes in poor or developing countries, there are more "scientific" explanations for malformations. These are often not consciously seen as punishments, or as the already written fate. At the preconscious level, a mother often worries about whether something she did or failed to do might have contributed to a malformation in the baby, however, and she may feel guilty.

However, modern technology, for all its advantages also presents new dilemmas to the mother. When an infant in utero is already diagnosed with a major health condition, the parents have sometimes to "decide" what they want to do about continuation of the pregnancy, the kind of birth that they desire, or what measures if any to take from the medical point of view, once the baby is born. Also, there is the feeling of being a "carrier" of a genetic code that is abnormal, and then having to struggle with whether the couple would wish to have more children.

There are few scientific studies of these "new problems." Mothers are presented with diagnoses and malformations about which they do not know anything, such as "Kabuki syndrome" "Mitochondrial disease" and the information will often be obtained from the worldwide web in detail. The parents at times are given the option of seeking a termination of the pregnancy and they have to decide what they want to do, often without full information of the condition and deciding on religious and ethical grounds, as well as extended family pressures. If a mother is told in the second trimester that her baby will have a trisomy 21 and is offered the possibility of an abortion, what should she do? This is a very difficult dilemma and there is no "totally perfect decision" that will cause no regrets of some kind. Many mothers decide to leave everything in "God's hands" and may request that the baby should not be heroically resuscitated if he or she stops breathing. But other mothers want the medical establishment to "do everything" to keep the baby alive.

Infant Prematurity

Dealing with a premature infant, the prolonged hospitalization, and the sequelae that often accompany the condition have an important cultural dimension. A study with Korean mothers of premature infants showed that the traditional attitudes and values colored the reaction to the status of the baby. One of them is the sense of responsibility or "blame" of the mother for the problem itself; another was the stigmatization of a premature child or one with special needs, and the fear of expressing any negative thoughts about the whole experience. In their frame of mind, negative thoughts could bring about adverse events in the real world (Lee et al. 2005). Among the main causes of prematurity, there is chronic and severe stress, in the United States, young mothers, those who experience domestic violence and are in very difficult environments have a higher frequency of early end to the pregnancy and having to deal with a premature child.

There is a wide difference between poor countries and highly technological societies regarding extremely premature babies. In the more "modern" countries, it is possible to save very small infants, who may spend many months in a neonatal intensive care unit, undergo several surgeries, and eventually have to be fed with total parenteral nutrition, have a tracheostomy and ventilation in the long term, etc. The technology may not exist particularly in less urbanized areas of poor countries and such babies would just not survive. On the other extreme, in very technologically advanced cities, infants of little more than one pound in weight will survive and may develop important sequelae, from learning disabilities and attention deficit problems, to cerebral palsy, blindness, seizures and need to be fed by gastrostomy. These infants also represent considerable stress for parents who may have to devote most of their lives to the care of a child with multiple handicaps and this represents also a challenge for siblings. Public schools may or may not provide the required accommodations to have the child in the school setting and the child often develops a great sensitivity to illnesses and may not be a good candidate to attend school. Caring for a medically very fragile taxes the family intensely and may lead to "carer fatigue."

Stillbirth

Although less frequent now than in the past, the death of a child whom the mother has carried through a 9 month pregnancy can be a devastating experience for the parents, leaving emotional scars such as unresolved mourning, fear of having another child, and intense anxiety in subsequent pregnancies, as well as fantasies of having a "replacement child" in the next pregnancy, sometimes giving the same name as the one who died. Also, in many cultures there is the problem of what to do with the body of the baby and where the spirit of the infant would go. In the Catholic belief system, a baby who has not been baptized may not go to Heaven and instead "stay in limbo." In France, there used to be occasional shrines where still born babies could be buried and they would "briefly would be brought back to life" by the Virgin Mary, in order for them to be baptized, such as the "Lady of revival" in French *Notre Dame de Recouvrance* (Simpson 2014).

Infant Death

Similar explanations as those for illnesses or malformations can be invoked when an infant dies, which is one of the most painful experiences parents can go through. Cultural and religious beliefs help to alleviate the pain of this event.

In many parts of Latin America, from Mexico to Chile, the death of an infant is often referred to as the death of an "*angelito*" (little angel) and the funeral rituals may be different than those for an adult. In Chile like in other countries, people may be dressed in white (instead of the usual black) and the dead baby may also dressed in white clothes, and adorned with motifs that resemble a small angel (Simpson 2014).

In many cultures, an infant that is very small is thought not to "feel anything" until he or she reaches a certain age, for instance, 3 months. Perhaps, due to the previously high infant mortality in many places, the mother does not experience, or may not manifest, much grief if such a small infant dies. The "personhood" is only achieved months later (Friedl 1997).

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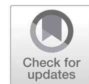
Part IV

Migration and Working in Mental Health with Families of Different Cultural Backgrounds



18 The Healthy Immigrant Effect and the Question of Acculturation

Hakan Sahin and J. Martin Maldonado-Duran

Is There a Healthy Immigrant Effect?

This chapter focuses on the issue of differences in health status and outcomes, including mental health, between the host population and their immigrants in several countries. Are there any commonalities among the people who migrate? How would they compare to those families who "stay in their country" and how do they fare once they arrive in the new land? Immigrants may wonder if they should try to acculturate and embrace totally the new culture (if they can), or whether they should "remain" similar to the people from their place of origin.

These questions affect immigrants, who may feel uncertain about how to be, how to behave in various social settings, and how to raise their children. What should they tell them about their identity? What language should be spoken at home in case they also speak the language of their new country? What holidays should they celebrate in their home, the old ones, or the ones that are held in their new country? What religious observances and other traditions that were meaningful in their country should be held, particularly if they are not important or even understood in the new place?

We address mostly the commonly observed migration from a poor country to a more industrialized one, wealthier and in need of workers. The facts noted here would not apply to "refugees" necessarily because they may be fleeing situations in which their own life is at risk, or their freedom, and they might face a choice that is different than migrating in search of "better opportunities" or a different way of life.

Immigrants due to work advantages, who lived in poverty or unemployment in their country of origin, or very harsh circumstances, may have some strengths and weaknesses in common. The question of whether healthier or more resilient people migrate is addressed, and the paradox of the "healthy immigrant" is explored. We also focus on the question of how to survive in the new country and whether acculturation should be uniformly recommended, that is: acquiring the ways of thinking, values, symbols, and ways of behaving that are common in their new habitat. If there is a healthy immigrant phenomenon, this may mean that some strengths of the immigrants, often from traditional cultures, may have protective effects which may be overlooked or devalued.

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The Migration Experience. Moving Abroad

Most countries in the world are not entirely homogeneous and some are extremely diverse. In a country like Nigeria, there are three major regions, broadly speaking, Hausa, Igbo, and Yoruba. They have three different corresponding "main languages" and cultural groups. However, in the country there are many additional cultures and languages (estimated around 400 different languages). For those who live there, it might be remarkable and such diversity may mean very important distinctions, even though from a distance the people seem to an outside observer as "very similar." The same can be said regarding China, India, the Philippines, Belgium, or Spain. Different "nationalities" coexist in the same country. If a person migrates from one part of the country to another, the experience may be similar to someone who migrates from Turkey to Germany in some respects. At times, there is a friendly welcome of "the immigrant" or not, even when the people involved are from the same country. There may be discomfort with the different language, costumes, and behavior of the newcomer in the host region.

In a "quasi-globalized" or highly interconnected world, with better means of mass transport, mass migration may appear as a modern phenomenon, but it is not. There have been exchanges and migrations for thousands of years, as well as mixtures of cultures (Greeks, Phoenicians, Chinese, Nordic people invading Southern Europe, etc.)

Increasingly people in industrialized countries are exposed to immigrants who come in search of opportunities, work, freedom from prosecution in their own country, drug wars, state terrorism, and civil wars. People from those typically poor countries, centuries ago, were also exposed to newcomers in the form of invaders, conquerors, colonizers, etc. (e.g., from Spain, France, England, the Netherlands, Germany)

Migration has become at times a preferred option due to economic crises in many low-income countries, plus conflicts, drug trafficking, and very large inequalities in individual income between countries. An increasingly frequent cause for migration is "environmental migration," as some areas are affected by floods, tsunamis, earthquakes, etc. requiring the some of the population to relocate elsewhere.

It is estimated that in Europe, there are presently around 25 million immigrants, and that in cities like London, Amsterdam, Brussels, and Frankfurt, around 25% of inhabitants are foreign-born (Rausa and Lloyd 2012). In the United States, there are about 50 million immigrants. In Asian countries, there are around 25 million immigrants. In 2015, it was estimated by the United Nations that there was a migration of 244 million of people (Rivera et al. 2015; United Nations 2014) which is equivalent to about 3.3% of the world's population (International Organization for Migration 2018). Recently, the United Nations accomplished a global compact between nations to deal with the problems related to migration, refugees, and displaced peoples. The treaty is called the Global compact for safe, orderly, and regular migration (GCM). Of course, treaties might be signed but the reality on a given setting may be quite different.

An important dimension of migration is the movement of money from one country to another. This tends to occur largely from the sending and receiving of remittances. Often, families who have migrated to a wealthier country, where the immigrants have found employment, feel the obligation to send money to their relatives (sometimes children, parents, siblings, or others) in order to assist them in the situation of poverty. Countries benefit from those remittances. It is estimated that Mexico and El Salvador, for instance, have a high proportion of their total income from those remittances. It is estimated that the total of remittances in 2015 was the equivalent of 582 billion dollars (International Organization for Migration 2018). The top countries which receive remittances are India, China, Philippines, Mexico, and Pakistan. Among the countries from where the most remittances are sent to other countries are the United States, Saudi Arabia, Switzerland, China, and the Russian Federation. For some countries, like India or the Philippines, where large numbers of

people migrate to other areas, the term "diaspora" has been used. The preferred term nowadays would be transnational communities, as people from certain backgrounds maintain contact with their countries of origin in many ways, including mass communications and media. This allows people to be current about the news and entertainment from their country of origin, which in the past was impossible, but due to the internet and other media, is now possible.

If one thinks of the world as divided between North and South hemispheres, there is approximately the same amount of immigrants from "South to North" as "from South to South." The population from Latin America who migrates tends to be less educated than the migrants from China, India, and the Philippines. Also, the so-called brain drain phenomenon (i.e., the migration of more educated persons to industrialized countries) is more prevalent for women than for men. It is estimated that in the National Health Service of the United Kingdom, more than a third of physicians are foreign-born, and something similar occurs with nurses. The main contributors are India and the Philippines.

This is only one aspect of the feeling of duty and obligation, as well as connection and links that immigrants keep with relatives in their home countries. Many migrants from Mexico have traditionally gone "back and forth" given the fact that the United States and Mexico share a very long border. Immigrants in many of those receiving countries will work in "services" (including domestic help, hotels, and others) as well as manufacturing, construction, and agriculture.

The migration experience can be quite dangerous, certain areas have a higher number of deaths, like the border between Mexico and the United States, the Mediterranean Sea for people who try to reach the European Union from Africa, and the different areas of the Middle East. The wish to migrate also gives rise to a number of "brokers," *coyotes* (human traffickers), and other transport businesses that may take advantage of those who they transfer. Even if there are no deaths, there may be financial extortion, sexual exploitation, or confinement of people against their will.

Who Migrates and Who Stays?

One thing is immigration in order to search for "better opportunities" or to escape poverty, and a different proposition is to be forced to migrate due to an immediate danger of being killed, persecuted, etc. this should be taken into account when discussing the characteristics of immigrant and who is "healthier." The conditions faced by people prior to the migration have to be a factor in their adjustment to the new country**.** The gender of the immigrants globally is about equal for men and women: 52% are men and 48% are women. The majority of immigrants are young adults, who can readily incorporate into the work pool of the host country. Many countries benefit economically from the contributions of immigrants, something that is not always recognized (International Organization for Migration 2018).

An additional aspect of some areas of migration is population growth. Countries like Germany, Italy, and Japan, would have a diminishing population, were it not for immigrants (Loran et al. 2008). Several countries have a problem with an aging population that does not stay in the "workforce." It can be argued that much of the undocumented migration into the United States from Mexico and Central America is related to the need of workers in multiple service and labor sectors, that would be hard to fill with the native population. Some countries get in influx of young immigrants who are going to have children, have them go to school and be engaged in work.

One might think that in traditional societies it would be mostly the men who migrate, but as noted half of the immigrants are women, at least in studies looking at immigrants to the United States and Europe (United Nations Department of Economic and Social Affairs-Population Division 2013), but it is true globally.

Since immigrants are younger, of reproductive age, this may increase the fertility rate in the receiving country. Those who migrate in general are healthier than people of similar age and background who stay in their own country (Park et al. 2009). It could be that those who migrate are more apt to take on hard work, have a lower body mass index than those who stay; this has been

called "selective migration" or a "salmon effect" (Palloni and Arias 2004). There is some evidence that indeed, the people that in a given country decide to migrate are healthier as a whole than those who stay (Jasso et al. 2000, 2004). Several studies have shown that the "healthy immigrants" are not only healthier than the people of their age from their host country, but also healthier than similar people from their home country (Antecol and Bedard 2006; Park et al. 2009).

Even when a place is very distressed economically, some people decide to leave and have the wherewithal to gather resources or the determination to leave and undertake a trip to a new land. Other people from the "same background" prefer to stay and deal with the local circumstances despite its adversities. What are the differences between these individuals or families?

The same question could be asked about the people who flee from ethnic, religious, racial persecution, or who are victims of state terrorism (as in the various dictatorships and military regimes that are endured in many countries), and also in dire economic circumstances such as in Yemen, Somalia, Haiti, and Honduras. Little research exists on what makes some people migrate and others not.

The notion of "healthy immigrants" is a multifaceted one, which generally implies that the people who migrate to another country bring with them certain behaviors, customs, and habits that are protective, and who show these traits through a number of health indicators. This has been studied mostly in migrants from "underdeveloped" to industrialized countries, for instance with immigrants from Mexico to the United States, from Turkey to Germany, but it seems to exist in many other groups. The healthy immigrant effect has been found in many studies in Western Europe, the United States, Canada and Australia and the United Kingdom predominantly (Gushulak 2007; Kennedy et al. 2015). The studies have involved many immigrant populations such as Latinos to North America, African, and Turkish immigrants to Northern Europe (Austria, Germany, and Belgium) (Loran et al. 2008) and Koreans and other minorities into North America (Ra et al. 2013), and from former Soviet republics to other European countries, including now the Czech Republic (Štípková 2016). This phenomenon in the "real world" may imply that there may be much valuable in "old cultures" and in the way people from ancient or traditional societies raise their children, eat, how they exert their body, and in their values. Some of these characteristics might be protective against health problems that affect people in rich and industrialized countries, such as obesity, high blood pressure, cardiovascular disease, substance addiction, and other mental health problems. What might be the protective effects?

A recent study from the Czech Republic (Štípková 2016) explored the rate of low birth weight among recent immigrants and the native population. It found evidence of the "healthy immigrant" effect. It suggested that the people who migrate there, a country with very strict migration policies might indeed have to undergo a selection process that biases acceptance toward the healthier population. This would not apply to the undocumented immigration to many industrialized countries however. The study also looked at the question of what kinds of jobs immigrants get, which might be an important variable in terms of likelihood to maintain one's health. Immigrants from the former Soviet Union to the Czech Republic tended to get hard manual jobs, with exposure to toxins and pollutants, while immigrants from Vietnam or Mongolia tended to be in the service sector, with less harshness but very long work hours (overwork). Despite the considerable devaluation of those immigrants by the majority culture, the population has better outcomes than expected, given the difficulties with access to prenatal care, lack of health insurance and the overall number of stressors, which are more severe than for the general population overall.

A study from Spain (Farré 2016) looked at immigrants specifically from Ecuador into Spain, due to a major economic crisis, in which about 600,000 persons migrated to Spain. There was evidence of better health indicators and perinatal outcomes in the immigrants comparing with "people who stayed" and with the local Spanish population, also suggests that the immigrants indeed were a healthier group to begin with.

Are There Common Characteristics to Immigrants?

The notion of a "healthy immigrant" is counter-intuitive. One would think that people who have experienced a lot of adversities throughout their life, such as poverty, deprivation, high levels of stress, persecution or other adverse circumstances should have much worse health than those who have grown in a country of abundance, with adequate health care services and without severe economic privations. At the individual level no generalizations are useful. It may well be true that persons who have undergone trauma, losses, experienced catastrophic events, etc. are indeed likely to have physical health and emotional problems on arrival in the new country.

In the past, countries who accepted immigrants have gone to great lengths to "screen out" immigrants who had a number of serious diseases. This applied particularly to infections such as tuberculosis, syphilis and others, and in many cases, a medical examination was a requirement for selection or before acceptance of immigrants in the host country.

Among such "standards" for immigrants, there is preference for younger people, less chronically ill or even without "mental illness," which is one of the criteria applied by some countries (Gushulak 2007). Still, it might be possible that there are certain characteristics in people who dare to leave their country: these might include seeking novelty, not being afraid of the unknown, or having an attitude of hope regarding the future, such as "giving their children more opportunities" than they have had in their country. There is little research on the psychological characteristics of people that decide to migrate in search of those opportunities.

A recent relatively small study comparing older Chinese immigrants into the United Sates with people born in that country of the same age, found a lower rate of cardiovascular disease and of asthma. Generally, the immigrants had a lower body mass index, tended to exercise more and to eat "healthier" diets (Corlin et al. 2014).

One of the topics in explaining the healthy immigrant effect is whether traditional cultures have a protective effect, or whether some cultures are more supportive than others in some respects. One would imagine if one had strong psychosocial support from a network of relatives, and being able to resort to them at times of stress, financial problems, etc. this might be beneficial overall. With immigration, this may be lost in practical terms, and this might account in part for the acculturation effect, that is, the decline in health advantage with the passage of time and as the immigrants adopt the habits of the host country (Singh and Siahpush 2002).

If one looks specifically at the perinatal period, as one of higher psychological vulnerability and of "psychic transparency" (Bydlowsky 2000), the question of migration is central. The availability of emotional and material support from her mother or sisters and the opportunity of performing certain auspicious rituals might contribute to maintain her emotional well-being. The caveat "if" she finds such ministrations supportive is important, as sometimes the "helpfulness" of the extended family might be perceived as controlling or trying to dominate what the young woman should do.

What Is the Healthy Immigrant Effect?

The generally accepted definition consists of the fact that recent immigrants from "third world" countries, poor areas and rural communities tend to have better health indicators and outcomes than people of the same age that are natives of the host country. This phenomenon has been deemed as paradoxical because it might be expected that people with less access to health care and facing more stressors would have worse health than the people born in the richer country (Kaplan et al. 2004). Another part of the phenomenon is that as time goes by, and the immigrants adopt the lifestyle, eating habits, exercise patterns and other behaviors of the "new culture" including their language, the immigrants' health outcomes start to worsen and become comparable to the ones of the host inhabitants.

As their acculturation proceeds, the immigrants tend to have similar rates of emotional disturbances, problematic perinatal outcomes and

chronic health conditions the more "acculturated" they are. The effect seems particularly true for immigrants of reproductive and middle age, but not so much for older immigrants (Kobayashi and Prus 2012). Several authors make a distinction between planned, that is, voluntary and forced migration. A forced migration might be dictated by adverse circumstances in the original country, such as civil war, ethnic violence, and persecution. Those immigrants tend to have more difficulties and face more stressors and often have already experienced significant trauma before the migration (Higginbottom et al. 2014). It is necessary to acknowledge that those immigrants may have different health care needs, dictated by their life experience of trauma, mistrust, and suspiciousness of governments and the health care system even in the new countries.

Healthy Immigrant Effect and the Perinatal Stage

Several studies have focused on the perinatal course and outcome of pregnancy among immigrants in several countries, for example, women from South East Asia in Canada (Hyman and Dussault 2000) and Latino women in the United States. Recently, migrated women have a lower prevalence of low birth weight and less pregnancy complications (Gagnon et al. 2009). This means lower incidence of premature births (Hamilton 2012), Cesarean sections and postpartum complications (Callister and Birkhead 2002; Heilemann et al. 2000). Women from traditional societies tend generally to engage more in exercise, walking, and other physical activities. Their diet includes more vegetables and fruits and less processed high sugar foods and high fat diets. There is also a lower prevalence of obesity and diabetes, including gestational diabetes. Other studies have found less likelihood of smoking and alcohol use and other substance use, such as marijuana and other street drugs as well as less severe psychological distress (Fennelly 2007).

While most studies agree with the better health outcomes mentioned above, there is evidence also that immigrants from poor countries have a higher rate of some specific health complications, such as neural tube defects due to a deficit of intake of folic acid. The women themselves have a higher frequency of anemia (Higginbottom et al. 2014; Nybo et al. 2007)

Aside from purely "physical" effects of diet and exercise, there may be differences in the amount of social support, extended family ties, and the adherence to rites and celebrations that amount to feeling connected and emotionally contained by other people. It is also possible that actually some of those traditional practices and remedies might be helpful to the woman who uses them.

The health conditions seem to change as women acculturate and become more like their hosts. This has been described as the "paradox of assimilation" (Rumbaut 1997) which suggests that the circumstances that immigrants find and adapt to in their new habitat are not so favorable to their health, including higher rates of depression and other emotional disturbances (Rumbaut 1997).

It is generally accepted that the "healthy immigrant" phenomenon consists of less complications and problems. The newborn is less likely to be premature and to have low birth weight when he or she is at term. Mothers have a lower prevalence of postpartum depression. All of this predicts a better mother and infant health, not only in medical/physical terms, but also emotional ones.

Healthy Immigrant Phenomena and the Young Child

It seems that the healthy immigrant effects extend to the children of immigrants, in the sense that they are also healthier than the native children, and that their health parameters tend to deteriorate the longer their mother has been living in the United States and the more acculturated she is (Garcia-Perez 2016).

The issue of immigration and having a baby immediately brings to the fore the question of what parents will do with the baby: tend to the child in the traditional fashion or in the ways of their "new country." Often, nurses and pediatricians eagerly impart advice on these topics, which

may run counter to the practices of the immigrant, learned from previous generations. This applies to issues of feeding, sleeping arrangements, bathing, and how to respond to the baby's needs for touch, carrying, etc. It will be a topic for years to come as parents are exposed to different child-rearing strategies and values they may not comprehend or like. The issues of acculturation and assimilation will become paramount in this respect.

Recent immigrants are more likely to initiate and or maintain breastfeeding of the baby, which is well known to have health benefits for the infant and also to foster patience and tenderness in the mother (Sakala et al. 2016). A recent study from Ireland found approximately double the rate of breastfeeding among immigrant women versus the local Irish mothers (84% vs. 46%) (Nolan 2012; Nolan and Layte 2014)

What Is the Evidence Against "Healthy Immigrant Phenomena?"

Access to Healthcare

In some countries like the United States, there has been a recent trend toward reduction of access to health care for undocumented immigrants, and poor people in general, which could have a negative effect on the overall health of both groups. The consequences of prejudice, racism, xenophobia, and higher stressors in general could add additional burdens to immigrants and have a negative impact on their overall health and adjustment. However, for the people who have a legalized status, acculturation may be associated with greater access to health care (Lara et al. 2005). Also, several studies in some European countries, such as France, Belgium, and the United Kingdom have shown that the health status (not necessarily mental health) of immigrants is worse than that of the native population. A study by Moullan and Jusot (2014) considered country of origin and receiving country, as they have differences in access to health, and the conditions of the immigrants also may be different on arrival.

Acculturation, Assimilation, and Its Alternatives

There are multiple definitions of "acculturation" but generally they include adopting the new language in the host country, starting to celebrate the local holidays and adapting to the diet and health style of those in the host country: leaving behind the old traditions and celebrations.

There is controversy as to what is acculturation. One conception is that this is a "one-dimensional concept," that is, a linear process: an immigrant is in one extreme not acculturated at all, holding to old traditions and beliefs, and on the other extreme totally embracing, adapting, and assimilating entirely the "new culture." A more realistic and complex concept is "bi-dimensional" in the sense that human and family behavior is not that simple. People may adopt some values and practices, while not others, and to have "partial" acceptance of beliefs and habits, while adopting others for different issues in a person's life (Lara et al. 2005). This includes the possibility of "being bicultural" and feeling that this is an adequate compromise.

The effect of acculturation may be quite profound, one may decide to keep or to change the connections to one's own background, and social networks. In embracing a new cultural strategy, for instance, regarding what it means to be married and how the partners in a couple relate to each other, the entire family may alter its dynamic after acculturation. A common scenario is: one of the spouses, for example, the wife is exposed to a more "democratic" or companionate way of relating to her husband, where he is involved in all the child-rearing activities, cooks, cleans the house and is the confidant of his wife, as well as friend, etc. In this situation, the husband may not be as interested in such a marriage in which his mental image of what a husband does is very different. Hey may hold to traditional practices in which he is the head of the household, has the last word, and has to "give her permission" to buy things or even go out on visits. She may then feel frustrated and disappointed, having adopted a new notion of what it means to have a marriage while her husband has not changed along with her.

By the act of migration, the man or woman in the parental role may have had to change occupation, and this may mean the loss of a prestigious social role and recognition. One of the authors worked with an immigrant family from Bangladesh. The husband used to be a literature professor in his country, and after migrating to the United States was working at a fried chicken restaurant, while his wife remained at home. The same occurs with some physicians who upon migrating have to work as assistants to nurses because of issues of revalidation and recognition of their training.

Another phenomenon can be the reversal of roles compared with the "traditional ones." If the woman is the one that works outside the house, and the husband cannot find suitable employment, this may be a destabilizing factor in the relationship, which may or may not be acceptable or processed adequately by the husband. Even if he accepts the status quo, he may see his prestige in the family quite diminished and feel inadequate. The extended family or a circle of acquaintances also may weigh heavily in his mind as being critical or disapproving of his new position as a "stay home father." There are multiple examples of these "new roles" that parents may have to adopt, not to mention the "adaptations" they may have to do caring for their children, for instance, leaving them in child care. If both parents have to work outside the house due to their multiple familial obligations, they may feel pressured to leave their baby in a child care setting, even when traditionally this would never have been done, as the baby always would be with the parents or a close relative.

Although the epidemiological findings on the "healthy immigrant effect" are a global overview of health indicators, that may be superseded when the individual or family have been exposed to severe stressors or traumatic events in their past such as the death of close relatives, torture, extreme poverty and inability to have any formal education as they had to work as children. These scenarios are not rare, but very frequently seen in young families from rural Mexico or Central American countries, for example, where children may start to work in the fields at 7 or 8 years of age and education has to be sacrificed.

The overall question still remains: what makes immigrants resilient in the new country? What gives them the strength to leave their country and family behind and try to find a new life elsewhere? Also, why would it be that with acculturation there may be a heavy price to pay? The findings from several studies indicates that for women, for increasing acculturation there is a higher likelihood to experience depression, including pre and postpartum. Also, the general evidence in most countries suggests that any "advantage" that the immigrants had in health status, tends to evanesce with the passage of years, when presumably they increasingly adopt the customs and habits of the host population. This suggests the question of what that might mean for the immigrants to adopt the new ways of life. A Latino woman thought she had an answer when she offered: "after several years of being in this country (in this case the United States) you become very selfish and lonely."

A related concept is "assimilation." In many countries, there is a prevailing idea that all immigrants go into a "melting pot" where slowly everyone becomes uniform, at least in beliefs, language, values, if not ethnically. This idea had been very popular in the United States and other countries several decades ago. People advocated that once people migrate to a host country, they should "blend in" with the host population until they become indistinguishable, or become "similar" to the locals. This notion is against the idea of multiculturalism or pluralism. The notion of "assimilation" is regaining popularity in the United States among some political sectors, and also in Europe. In the United States, some groups advocate "English only" use in all transactions in every sector of the public life, even elementary schools. Decades ago, children who spoke Spanish in several states in the South of the United States were forbidden to speak Spanish or punished for it.

In the scientific literature on assimilation, a related notion is "pathological assimilation." This term has been used to indicate that as the immigrants become more like their hosts, their health indicators worsen. In that concept, assimilation is "bad for the person."

In the United States, it used to be thought that immigrants from Norway, Sweden, Germany, etc. would, after one or two generations post-immigration, become indistinguishable from the

rest of the US population (meaning Euro American population). However, this did not apply when people were from a "colored" ethnicity (Rumbaut 2001). The "assimilation" was a more ambivalent possibility when there were marked "physical differences" between populations. This issue is of great importance in the perception of the immigrant: whether the local in habitants would ever "accept" him or her as "one of them." There are visible and less visible barriers such as racism, segregation, or subtle rejection, obstacles to the social mobility of minorities and the like.

A crucial factor in "assimilation" is how different the cultures might be. If there are major differences, that process might be difficult. Some authors refer to assimilation as "subtractive" when it is expected that the person would "lose" practices and beliefs, and substitute them for the local ones. This is in contrast to "additive assimilation" where a person or family gains new costumes, habits, beliefs, and keeps some of the old ones so a new blend is established. In this process, one does not necessarily have to give up everything from the past: a family might not have to "choose one language" but to use two languages, one at home and one outside.

Pluriculturalism

One of the ways of coping with migration is a "flexible acculturation" or developing a bicultural or multicultural identity. That is, incorporating elements and customs of different cultures, and even using different languages in various contexts. A person could "navigate" different cultures with a "set of behaviors" that are suitable to that culture and be able to function within that framework and then a different set in another context. Various Afro-American health professionals have written about the need to "speak differently" in a professional or work context, and using a more familiar speech in the home or with relatives or friends. The same can be said of children of Latino parents who may speak perfect English and yet speak in Spanish at home, even with an accent similar to that of their parents, and use "different Spanish accent" with Spanish-speaking people from various other countries. Something similar may occur to an Arab-speaking person from Morocco who deals with people from Egypt or Iraq. There may be many words and customs in common, but significant differences that a person could learn to navigate.

Fig. 18.1 Role of siblings. (Original artwork by Ana-Marcela Maldonado-Morales)

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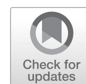

19 Working with Immigrants and Refugees

Youssef Hrar and J. Martin Maldonado-Duran

Mental Health Interventions with Immigrants and Refugees During the Perinatal Period and Early Childhood

"When I came to this country, everything seemed so different and odd. The way people looked, the way they talked, how they dressed, how they related to each other. I could not understand the language very well, despite having studied some English in my country. They spoke really fast and used a lot of words I did not understand, they call it slang. Everything seemed to be like in a movie. When people started talking to me, my mind went blank. I was not really listening, let alone understanding. I wanted to be polite and just tried to smile and nod as if I agreed with everyone. The information that they gave me I forgot very quickly. There were so many pieces of new information. They would ask me my "zip code" in agencies that help people and I did not know what that was. They spoke with acronyms I did not understand, and I was afraid to ask. It took me about a year for everything to seem less strange."

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"Cultural Sensitivity"

In many areas of medicine and disciplines of mental health (psychology, psychotherapy, counseling, psychoanalysis), there is an increasing awareness of the need to be culturally sensitive. But what does this mean? In many settings in North America it often means a brief presentation or a few hours of being exposed to "exotic cultures" and being careful not to offend anyone with stereotypes and assumptions about "other people." Such courses are taken at times as a way of fulfilling a requirement to "take into account the patient's culture" and beliefs. Then everything goes back to normal and the same practices and assumptions are more or less maintained, despite this "sensitivity training."

Perhaps a useful way to discuss the transcultural work is to consider from Marie-Rose Moro's statement (Baubet and Moro 2009): "every relationship is transcultural." This implies that not only in clinical work, but in schools, work places, marriages, friendships, etc. a person's history, sense of self, ideas, and assumptions are determined by culture in the broad sense.

In a clinical setting, and particularly in the area of mental health, the cultural background of the persons in front of us interacts with the clinicians' backgrounds. At all times, we gain impressions, assess statements, perceive motions, gestures and expression of emotion from our own

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cultural frame of mind, to which we are often blind.

This implies that clinicians, like the families and individuals they serve, will have prejudices, assumptions and ideas about “the other” of which they will not be aware. One tends to unconsciously assume things about those with whom we interact, and those presumptions will color our impressions, reactions, and what we say or do not say or do. It would be useful if the clinician interacting with a given individual or family wondered what prejudices or notions might be in play in his or her mind, particularly if unusual or strong reactions of dislike, fear, anger, disapproval, or devaluation are detected. This type of introspective work would certainly improve the clinician’s level of cultural sensitivity among other benefits.

The Mind-Set of Clinicians in a “Transcultural Situation”

How can one work with a person from another culture? There may be interactions that are particularly difficult and questioning one’s blindness to them might be helpful.

The clinician has the contradictory task of seeing what “is the same” and “what is different” about the person/family seeking our assistance. Only if one is able to perceive the “human condition” of any person no matter how different, unique, or odd their beliefs or practices are, one can relate to their situation: expecting a baby, having had a perinatal complication, having suffered the loss of a child, most people can relate to the possible reactions. There is something very basically human about people from any background to which we can relate. Similarly, even though the clinician may be from a very different ethnic or social group, the patient must feel that he or she understands, empathizes, and is able to comprehend what the patient/family is going through, and then offer a helpful view, understanding, or empathy.

On the other hand, a common problem is “not to talk about differences” as though they did not exist. The fear of prejudices, devaluation, or appearing judgmental may prevent the clinician from asking questions about a person who has very different beliefs or practices. One may tend to assume that the person is “like us,” or wants to be like us, has the same aspirations, view of the world, of what being a father or a mother is, or what they may want for their child. The clinician has to feel a minimum of comfort to ask about different points of view, assumptions, and practices and to try to understand them within the world view of the person who seeks help.

A technical strategy may be called decentration (Wa Tshisekedi 2008) in the sense that the clinician is able to put himself or herself in the frame of mind of the other, suspend one’s own intuitive or automatic appraisal, and try to see things from the other person’s view. What would it be like if one thought that whatever adversity that happens is due to “karma,” i.e., to a debt for a previous transgression that occurred in a former reincarnation? or that it is their fate to endure a difficult event and that everything is “already written” in the person’s destiny book? The patient or family may think that a perinatal complication is written in their book of life decided by God and has to be endured as such. For example, the parents of an 8-year-old boy that passed away after battling cancer for many months, were extremely sad but had a smile on their face while discussing their child’s death. They referred to it as “Allah’s will” and said that their little boy was now an angel, resting in peace. This approach and ideology appeared to give them a lot of strength to accept the terrible loss they had endured. It also seemed to allow them to move through the grief processes and stages, as the acceptance phase had already started in some form. They had a newborn boy about a year later and named him after his late brother.

In another scenario, a family may appear very stoic and inexpressive of emotion, even in the face of a severe illness in an infant, or after the death of a small child (Foss et al. 2004). One might assume that there was “no attachment” to the child, when in reality the person has a different way of experiencing grief: the open expression of sadness, particularly in front of strangers may be considered unseemly and a burden on the

other. The mother or father going through that experience may think that they must “endure inside” their feelings of pain and sadness, and that this is how these losses should be processed. This may be how they saw their parents and other relatives deal with losses.

A better understanding of those etiological theories, explanations, and reactions is facilitated by taking into account some cultural norms and strategies in the social background of the individual or family.

There are a number of challenging situations that could be described in great detail, pitfalls and “cultural clashes” that the clinician needs to consider in working with a person from any background.

We describe some common scenarios that may offer particular difficulty for clinicians regarding the “cultural factors” involved.

The Client and Therapist of the “Same Background”

This is a common pitfall in many clinical settings. If a therapist or clinician is from a determined ethnic background, that does not mean that all families from that particular ethnicity or origin should be treated by that person. Also, it does not mean that such clinician should have an entire caseload of the “same type of families.” Often an Afro-American psychotherapist may be automatically assigned every African American family just because it is assumed they will “feel more comfortable.” This at times means that other clinicians in that setting may find it difficult to relate and/or to understand families from that particular provenance. This maintains a stereotype of “like working with like.” Clearly some families might have great reservations, but others might not and the interchange of different views and experiences may benefit both the family and the clinician.

It often happens that families may indeed feel more understood by a person from a particular ethnicity or background, or who speaks the same language, allowing for a more rich and complex communication with that therapist. However, it must not be assumed that just because someone is from a particular country or ethnic group, this makes him or her competent to work “only or predominantly” with clients of that group. This has been called a “particularist approach” to the matching between patient and therapist (Erdur et al. 2003). It assumes that people improve more, or stay longer in treatment, or find the therapy more credible if the patient and therapist are from the same ethnic background, sexual orientation, or both are handicapped for example. There is little empirical evidence for this, and some studies have found little difference between outcomes just based on similar ethnicity of clients and therapists (Erdur et al. 2003). When there is a language barrier, the therapist and the patient/family speaking the same language may indeed lead to a better experience and outcome. The same could apply when a group is considerably devalued and segregated, so the family may feel more comfortable with the therapist of a similar background.

In the United States, a common assumption is that a therapist from Spain, Chile, or Colombia is “Mexican” and therefore would prefer to work with those families, or that the families would favor such clinician. The same could be said of an “Asian” therapist who is thought to automatically anyone with a particular “Asian phenotype.” There may be considerable differences in practices and beliefs between different countries and groups within them, even though they are lumped together as “Hispanic,” and there is no a priori uniformity.

In a mental health service, a more complex approach to assigning therapists would be useful: the interest or expertise of the therapist with particular problems or issues, the variety of the clientele of the clinician, the interest in particular situations, the needs of training and exposure of other therapists, etc. Assuming that a clinician from a particular ethnicity or social background “understands everything” about a family is a false idea. Sometimes it is useful for a family to “have to explain” what they mean by terms such as “respect,” “act like a man,” “what a wife should do,” etc. rather than just imagining that people from the same cultural group are thinking along the same lines.

Having the opportunity for supervision or consultation in psychotherapy with specific situations or families, as well as clinical discussions of particular cases, reflective discussion of the individual/family and the clinician's reactions would help to develop increasing capacity in the staff to deal with multiple situations (Banks 2001). The consultant or supervisor may help the clinician recognize biases, particularly common are those based on European perspectives on what constitutes normalcy, "boundaries between family members," and independence which a therapist might unwittingly attempt to impose to a family for which those are not important aspects of human development.

There are a number of instruments designed to detect prejudice in the therapist (Katz and Hoyt 2014), for instance the Multicultural Counseling Inventory (Sodowsky et al. 1994), or the Implicit Association Test (Greenwald et al. 2003) which helps to detect automatic prejudices against Afro-American people, among others. They may help detect how much bias there may be toward often devalued cultural groups, like Native Americans, Hispanics, African Americans, Muslims, etc.

Prejudice on the Part of the Patient/Family

A difficult situation for any mental health service is the request for a particular "type of therapist" (e.g., a Christian one), or the "veto" of a clinician from a certain background. The father of a young child who was requesting through a telephone call a consultation for his son's difficult behaviors, upon hearing the accent of the clinician asked if he was "one of those Muslims." The clinician was taken aback (he was not Muslim) and all he could manage to answer was "I wish." The father was rather surprised and made the appointment. He had been in the Iraq war and had very strong feelings about Muslim men, to whom he referred pejoratively as "sand niggers." In this case despite the physical appearance and the accent of the therapist, a therapeutic relationship became possible and the father's traumatic memories of his time in the Iraq war lead to understanding his feelings, and once these came to the fore the "prejudice" became more a question of the unique experiences he had had. A more suitable response by the clinician would have been "what is the reason for your question about Muslims" or something along those lines. The fact that the therapist was not afraid to embrace "the Muslims" seemed to prove to the father that he could talk openly to the clinician about his anger problems, which often were taken out on his little son.

In another instance, a young mother of a three-year old boy who was being seen for frequent temper tantrums and very difficult behavior asked the therapist "what he was" referring to his ethnic background. The therapist answered: "I am Mexican." The woman showed much empathy and said "don't talk like that about yourself" (implying "don't be so harsh on yourself") with considerable compassion. She had thought that "Mexican" was an insult as this is how she had heard it all her life, and only then realized that it also referred to a person born in that country. She was somewhat mortified and discussed her feelings about "Mexican people" against whom her mother had warned and who were seen as impoverished and potentially thieving people.

Sometimes the prejudice might stem from the cultural belief that the need to consult a therapist is not justified or needed. The patient or family might be very reticent to see the clinician in the initial phase. The clinician would have to explain his role and build a relationship of trust with the family. Using the strategy of de-centration discussed previously would be crucial in this scenario. It would allow the clinician to fully understand the source of the prejudice he is facing and turn it into a successful collaboration. Despite all his or her efforts, the clinician might fail to overcome those challenges. If the prejudice were very intense and entrenched, it might be counterproductive to attempt to engage with a person who is going to be frightened or has strong dislike or hatred for people of a certain background. The clinician or the organization has to decide, perhaps on a case by case basis, how to deal with such "vetoes" or "special requests" from families for a particular "kind" of therapist.

Hiding Behind One's Culture

At times a family or couple that experience difficulties may justify their behavior as based on "their culture," as a way not to deal with their individual or family issues related to their own life experiences and relationships. The clinician should consider carefully whether certain assumptions are "cultural" or are unique to the particular individual. Recently one of us worked with a young father from the Philippines who was particularly authoritarian with his wife, who "cried in silence" and just prayed when her husband would become enraged, scold her, accuse her of unjustified infidelities and exhibited very paranoid behavior in general. He said that is "the way men are in his country, particularly from Mindanao." While he was not challenged, when he started exploring his own childhood marked by an abusive father and a frightened mother, the source of his fears and the identification with authoritarianism became more "personal" than "cultural." When we worked on these memories and current circumstances, unique to his life, he gradually was able to become less controlling and more empathic. The clinician might have just taken his statements at face value, but still it would be very hard to believe that all or even "most" men from Mindanao were as controlling, insecure, and paranoid as the person affirmed.

The question of disciplinary practices and culture often comes to the fore in the clinical setting, particularly toward young children. At times parents say that "this is the way things are done in their culture." For example, the parents of a four-year-old boy with Down syndrome were very angry that he was disobedient and aggressive. The little boy had very limited language use and mostly growled to convey his emotions. As we explored the reasons for his frustration, the issue of physical discipline arose. The boy's mother was very controlling and frustrated, and she was originally from an Asian country. She wanted the boy to be normal, and "like every other child." She would hit him with a clothes hanger on the plantar area of the feet so that "she would not be reported" for child maltreatment by her child's preschool teacher if any bruises were left. She would hit him and threaten him often with doing precisely that. She said that: "everybody does it in my country." However, as we explored her desire that her son would become normal, and not accepting the reality of his language and intellectual limitations she started to mourn the loss of "an ideal child." She was able to think about how her son might feel being hit on the feet, his fear and his frustration. She started to accept the child that indeed was in front of her. She stopped hitting and accepted alternatives to teach the boy other ways of acting, less aggressively. She was able to acknowledge that she had been angry at her son for not being "normal."

In general, it is best to avoid any debates that involve religious dogmas, as the beliefs are based on faith and cannot be contested. Parents of various backgrounds fairly often say that children should be hit when disciplined as: "the Bible says so" in several places. A very angry grandfather was regularly spanking his four-year-old grandson for being difficult and strong-willed. He seemed frustrated that the boy had been conceived unexpectedly by his very young daughter, 18 years old, who had not married the father. He "allowed them to live at home" but was clearly resentful. David, the little boy, lived in a fairly toxic environment of tension, blame, constant reproaches, and threats (of being "kicked out") toward his quite depressed young mother. The grandfather said that in his culture (he was from the North of Mexico originally) people go to the psychiatrist only when they are crazy, and spanking is practiced regularly. He had joined the sessions only reluctantly, at the request of the therapist. As the issue of his constant threats and spanking David with the belt came forward, he kept saying that he was evangelical, and the Bible dictated this. The therapist did not challenge him until several sessions later. He asked the grandfather if he imagined Christ spanking children. The grandfather was taken aback, he remained silent and did not know what to say for a while. He finally said "no." This opened the door to a discussion about why the boy might be so angry and what could be done to set limits without physical aggression. He stopped the hitting and the boy seemed less angry and scared. However, it is

seldom very productive to engage in religious discussions of this sort.

Pretending There Are No Cultural Differences

Sometimes a sort of "collusion of silence" develops between the mental health clinician and an individual or family when they are from different cultural or ethnic background. They both hope that the process will go well if they do not have to talk about the uncomfortable subject of marked differences when they exist. If there are some language challenges, or very different world views, it would be helpful for the clinician to put on the table such differences so that they can be discussed as openly as possible. If the clinician is "foreign" and the family feels uncomfortable, but they do not want to be perceived as "racist" or prejudiced it may be preferable to discuss what is happening and assess whether the therapeutic work can proceed (Cardemil and Battle 2003). If the family holds back discussing practices and beliefs that they suspect will be judged as primitive or ignorant, the clinician could encourage them to say what they "really think" and not to fear judgment, as the clinician is interested in learning how things are done in their family.

For example, a family from the Middle East might strongly believe that a Western mental health clinician would not understand their perspective and approach to difficult life events because of cultural and religious differences. Moreover, if the clinician ignores and does not address these differences, it would strongly reinforce their feeling. It is important for the clinician to initiate a dialogue about differences and perspectives for better therapeutic outcomes.

The Question of Interpreters

Translating figures of speech and words denoting complex emotions from one language to another is difficult and not everyone can do it just because they technically speak a certain language (Rousseau et al. 2011). The clinician can usually read the "language of the heart" to try to read the messages from the family instead of just focusing on the "digital" message, i.e., words. The behavior and the emotions are often more important than what people are saying.

The term interpreter is preferred to "translator" as the former is expected to have an ability to be a "bridge between cultures" and assist clinicians with some references or figures of speech that if translated literally might be misunderstood. A person with such training is essential particularly with less commonly seen immigrants or languages. The discretion and confidentiality of the interpreter is crucial so that people can actually discuss their painful experiences or family secrets. In one experience we had with a young pregnant woman in the hospital, this did not occur. The pregnant woman spoke Togolese and had become almost mute and developed a psychogenic amnesia. An interpreter from Togo had been present in a previous appointment with the obstetrician, and the patient had been told that she was positive for the HIV virus. The patient had been very scared, but the bigger problem for her was that the interpreter knew the patient as there was the very small community from Togo in that city. The translator told her acquaintances about the HIV infection and through telephone texts the patient started to receive, she realized that "everybody would know" about the HIV in her community. She felt she had lost face and it was then that she developed the psychogenic amnesia. When this was eventually processed with the patient, and with hypnotherapy, she "recuperated" her memories. She had forgotten her name, the names of her previous children, her maternal language, and only had been able to speak with a few English words.

The gender of the interpreter can be of extreme importance in some cases. A Muslim woman, for example, would generally feel extremely uncomfortable to speak about certain topics such as sexuality if the interpreter is a man. She might even request a female interpreter as well as a female clinician.

It is very difficult even for large hospitals or institutions to have interpreters for many languages, and even more so for smaller organiza-

tions. In some institutions, it is thought that a member of the staff, just because of their last name, or ethnic background can be an interpreter. This can lead to problems as the translation may be inaccurate. That staff member may feel pressured to "know the language very well" and not to appear incompetent. Also, sometimes the child of a patient is the translator, which may be unavoidable in urgent situations but puts a heavy burden on a child, particularly if the situation at hand is painful. The telephone services and the video conferencing that are available in many countries are not ideal but often are the only possibility available, particularly with languages that are less widespread. Mental health clinicians need to do their best to schedule "in-person" interpreters when possible and to be sensitive to the family's preference for the interpreter's gender when it applies. This would lead to an optimal level of communication.

Overcoming Cultural/Ideological Barriers

One could argue that part of the therapeutic experience for some young families would be to learn to trust a person that "is very different" from their background. This could be an African American therapist working with an Euro-American family, or a Caucasian French therapist working with someone from Vietnam, formerly a colony of France. At times these combinations are unworkable, but often it can be part of the exploration of assumptions and fears on the part of a family seeking help. A young "White" family from an inner city in the United States sought help for their baby who was crying excessively. The young mother was depressed and the father, also young, was frustrated and did not understand why their baby cried so much. As they sought help, the pediatrician referred them to a Hispanic male therapist. The young father was a "skinhead" and a "Neonazi." He had a swastika tattooed on his arm and spoke openly about this from the start, saying he was a white supremacist. The therapist interpreted this as a provocation and started to focus on the mother's and father's perception of their baby. The mother was eager to see her baby more comfortable and a number of sensory integration issues and high muscular tone were noted in the baby. The clinician gave the parents some suggestions on how to help the baby feel less overwhelmed by his sensory world and to help him calm (flexion positions, increased holding, massage, etc.). The parents came for a follow-up session and the baby had been crying much less. The father brought some "art work" involving Nazi imagery and one in which the words "to hell with minorities" were included. The therapist read these as an invitation to discuss his beliefs, and tried to engage the father by focusing more on the "personal experience" of the parents, instead of their political ideas. The young father had been in a "White gang" before and had grown up without a father. He was very resentful and felt unwanted and rejected. This was perhaps the source of his hatred for "the other." The therapist was much older than the young father. Gradually, as the latter expressed his resentment and then his sadness, the relationship with the therapist changed. He started speaking of "Mexican friends" and that "not all minorities are bad" and became more open. His rigid ideology of "hating" was in part concealing the unresolved pain and anger at feeling unwanted and neglected by his father. The experience with the "Mexican" therapist who did not counterattack immediately and tried to contain him seemed to be a therapeutic experience for him.

A father from the Middle East that came to the United states for his child's treatment was complaining that they were treated differently than American patients. He thought the staff was making them wait longer than other patients and would treat them in a condescending way. He referred to the staff as "*Kuffars*" which means "non-believers" in Arabic. He was certain that there was a discrepancy in the way they were treating his son compared to an American or to be more precise a Christian child. If we fast forward many months later, the father realized that his ideas were preconceived and erroneous. He confessed at the end of their stay that they had been treated "better than in their own country" and

could not thank the medical team enough for what they had done for his child.

Self-Expression

The "other" (the minority, the foreigner, the immigrant, etc.) may have difficulty speaking in the local language, English, French, German, etc. It is understandable that if a person uses very simple phrases and has a limited vocabulary, the clinician might conclude that as the patient or family does not think in a complex, nuanced or multi-layered way, or is not educated, but this could be a wrong assumption. In his or her original language, a person might express complex ideas, nuanced thoughts and feelings that might be difficult to put in the language of the host country. The therapist can supplement the digital communication with reading the behavior and emotion of the person (Fassin 2011). Some immigrants or refugees fleeing war zones may have to take work in unskilled labor despite their professional training (Chen et al. 2010; Erdogan et al. 2011). Also, in many cultures it is a matter of politeness to not speak about one's accomplishments and knowledge, but rather to minimize them for modesty and not to appear boastful or to be bragging. This is a different cultural stance than it is common to see in countries like the United States, where people speak more spontaneously and openly about their accomplishments. They do not expect to be the object of envy, but that other people would be happy about their good fortune or accomplishments. A Muslim new father from Iraq revealed the following:

"I was afraid of the neighbors. The Jewish center for assistance to refugees provided a house for the first few months after we arrived here. We could not speak English and it was very hard to move around. I hardly let the children go outside because I was afraid something would happen to them. At night I could not sleep, the sound of the bombs in Iraq and the memories of the people we knew and who were killed kept haunting me. I sometimes felt overwhelmed with feeding the baby. When she would cry, I would go into a panic, imagining something terrible was happening to her. In my country I was a mathematics professor and here I got a job delivering pizzas, but every little bit helps."

The Unspeakable

When working with an expecting woman or couple, there may be particular concerns about self-disclosure or talking about the pregnancy itself or the baby in utero due to regional beliefs. One concerns the gender of the therapist: for a very traditional Muslim woman it may be thought inappropriate to meet alone with a male clinician. A woman clinician might be more suitable, but if this is not possible, her husband or her mother or sister might be acceptable. Eye contact should be kept to a minimum and shaking hands with her on getting acquainted generally is inappropriate. Talking about some topics, even in front of her husband, may be difficult, particularly if there is marital conflict or disagreement. In many other cultural groups it is easier for the expecting woman to talk to a woman therapist, although if the male therapist explains the reason for the questions and the purpose of understanding, it may overcome an initial reticence. The questions should be tactful and allowing the woman to "save face" and not answer them.

Speaking about negative feelings from the start may be unacceptable. The patient may consider it is terrible to say anything negative about her mother, her father, siblings, her children, or her husband, even if she has such negative feelings. The person might think she should always say that of course she loves her mother, because it is her mother, for instance. Even if the mother has difficulties such as alcoholism, or has been abusive, this cannot be addressed at the beginning as it is considered a shameful revelation. The clinician may need to spend considerable time at first helping the woman or family feel welcome, not pressured and taking time to say what is happening in her own terms and to develop trust. The communicational style may not be direct and "to the point," but meandering and oblique. The same goes for other family members. The very business-like style of direct

questioning that is common in many modern countries may be perceived as disrespectful and too direct for the woman/family. Writing on a computer while talking (Van Dellen et al. 2008), or looking at the screen instead of at the family may be perceived as distant and cold if not disrespectful. Families of many backgrounds may not be used to answer difficult questions directly, but in a "meandering way," referring to other things, or giving many details that for our ears may seem irrelevant. This style of conversing, or telling a story is very prevalent in many traditional cultures and the clinician should be patient to try to grasp what the family or woman is trying to tell.

Many people from traditional societies are not used to verbal communication of feeling and internal states (Fazel and Stein 2002). This might include emotions like sadness, doubt, anxiety, and instead may manifest their emotions in a behavioral way. The expressions may be bodily manifestations, such as pains (headaches, back pains, muscular pains), digestive problems (cramps, diarrhea principally), urinary frequency, "heart" problems (pain in the chest, palpitations, tachycardia) among others.

Expressing ambivalence toward a pregnancy or a baby in utero is difficult in any culture. In some it might be almost blasphemous because a pregnancy may be thought to be the will of God or a blessing that one should not fail to appreciate. The woman may express her feelings through gestures and the tone of voice but not necessarily in words. In this case the use of an interpreter may make things difficult, as the nuances and the tones are hard to grasp at first, but with time it may be possible.

Speaking at all about one's pregnancy, about the baby in the womb might be considered "bad luck" or an ominous conduct that would bring negative consequences, particularly earlier on in the pregnancy. This may apply to many traditional women from African cultures, who may consider it taboo. In some of them, it may be thought improper to discuss the pregnancy details with strangers, as this might be a bad omen. Admitting that one is depressed, or very sad, may be thought unacceptable. Women may endorse feeling tired, having a lot of pains, having little energy, feeling exhausted and crying, headaches, back aches, muscle cramps, all of these may be present, but she might never talk about feeling sad or pessimistic.

Once the baby has been born, it may also be impossible to speak of negative feelings toward the child. It may require some work to suggest that the Westernized notion of "ambivalence" permits that one would love a person and still be angry, even at a baby, while still loving him or her intensely.

Group interventions might be more appropriate in some cultural settings than in others. Many women from traditional cultures may not be as concerned with "privacy" of their information and might be more able to discuss thoughts and feelings if other women also speak about them, such as marital problems, a difficult relationship with parents in law, or with one's children and doing so in a group format.

In a setting in Paris, Moro (Baubet and Moro 2009) has described a *dispositif* of transcultural psychiatry, which involves a mental health intervention with families, but through a group meeting, with several therapists and students from different backgrounds. The various members talk about the issues brought up by a family, usually an immigrant one. Instead of a "prescriptive approach" which is common in countries like the United States or the United Kingdom, they use an evocative one. Each member of the team discusses how the problem at hand might be handled in their own culture, if a shaman might be consulted, an infusion given, a marabout might be consulted or a priest, or some cleansing ritual may be preferred, or seeking advice from elders. The notion is that this allows people to feel accepted and free to say what "they really feel" and to introduce a relativism in terms of etiological theories and therapeutic strategies. Many of such interventions might be equally effective as, for instance, prescribing a psychotropic medication. The group emphasizes that this mode follows a customary practice in many cultures, in which a group discusses a problem and offers possible solutions rather than "individual encounters" which may be seen with suspicion.

In many cultures, it is customary to first engage in what in the West we consider as "small

talk" and to discuss various unrelated issues, to soften the social interaction and "smell the air," before going to the issue at hand. Issues and problems may be introduced gradually and only if the interpersonal climate permits it. People from very traditional societies will find it very hard to speak directly about a number of topics. Issues of maltreatment during childhood, physical abuse, neglect, and particularly of sexual abuse are considered taboo and not to be discussed, particularly not with a stranger. A person that discloses this might bring shame to her or himself, and to their entire family. Often this information is strenuously suppressed until it can be alluded to in an oblique way, implied, when there is trust in the therapist.

Something similar could be said about the status of marital relationships, particularly intimate relationships. It might be considered a betrayal to discuss issues of marital conflict or sexuality.

There are cultures that place a heavy emphasis on verbalization of feelings, emotions, and states of mind. Other cultures less so, and people then use other vehicles of communication, be it somatic symptoms (an ill feeling in the stomach, something stuck in the throat, headaches, backaches) as the language of their distress. Another way of expression is the posture, attitudes of the body, crying, being dissociated or distracted, and not remembering things. The modern tendency to address problems quickly with psychotropic medications often will be turned down for fear of addictions or "becoming dependent" or generally fear of taking medicines. This may be possible and indicated once the clinician has gained the confidence of the patient, but not too quickly. Latinos in the United States, for example, are a group with considerable misgivings about psychotropic medicines in general (Lanouette et al. 2009; Kaltman et al. 2014). This is all particularly marked during the pregnancy and postnatal stage (Lupattelli et al. 2015).

In cultures in which not much verbalization is common, drawing, art representations such as ceramics and collages may be more useful, to "put on the medium" emotions and experiences that may have been traumatic or the feelings one is experiencing presently.

Working with families may be a preferred modality if there is much stigma to the "individual patient" as being the weak, crazy, or the nervous one. Trying to normalize the reactions of the patient and to see them on the context of the family may be more acceptable. This can also mobilize strengths in the family to assist the person who is experiencing the most emotional pain. Also, other family members may experience similar feelings and this may help the patient not to feel so different, strange and as an additional burden. The relatives can provide support and reinforce some of the interventions that the therapist may have suggested during sessions.

Gifts

Many families from traditional societies are used to express their gratitude through gifts. They may offer a gift to the physician, for instance after a boy is born, this is customary in many Muslim families. In Latino families, the mother of a child may bring the pediatrician a small gift, or food that is considered special or a delicacy, the same is often seen in Philippino families. Rejecting the gift may be considered a major slight and a rejection, as though one were disgusted by their food or is rejecting a token of appreciation (Hahn 1998). This practice often runs counter to policies in many hospitals and clinics that prohibit personnel to accept gifts. If one must reject one, it is important to explain that it has nothing to do with the source or personal preferences. In general, the gift if it is not excessive could be accepted and explain to the family the policy regarding gifts for future reference.

Facing a Foreign Family

There is perhaps a "built in" reaction to people who are very different or who look very different. This might particularly true in highly homogeneous societies, as Japan or Sweden were generations ago. With exposure to "the other" and interacting with "foreigners," usually people come to appreciate the strengths and values of

other cultures and may embrace many of them. Increasingly large cities in the world are multicultural and people get used to different languages, foods, dress, customs, etc. With the rise of racist ideology in many countries in the last decade, fascist groups with this ideology foster this mistrust of the "other" and an "us versus them" mentality, emphasizing differences and the fear to be absorbed by the invading threat (Stanley 2018).

These issues are often not talked about, and many people would be worried about being thought to be "racist" or prejudiced. There is generally very scarce literature on the reactions of clinicians to their clients, except in psychoanalysis, which take into account the subjectivity of the patient and the psychoanalyst. There is also little information about the reactions of the clinician facing a dyad, a mother baby dyad, or a triad (mother, father, infant) who are from a very different cultural background.

There are many variables to consider in one's reaction to "foreign" patients: depending on the age, experience, gender, personal history, expertise, and cultural background of the clinician. These reactions are strongly influenced by the "work culture" or the place where the foreign family is being treated. Each work place has a "culture" which may or may not promote discussing or even acknowledging issues of differences between clinician and family. On one side a place or a center can be "open to all" or, on the other extreme, the presence of a foreign family represents "a problem" because of the need to find an interpreter and the general discomfort of not knowing what to do.

The experience of the family may be very different depending on the setting. A prestigious children's hospital in Montreal, Canada, has in its main entrance a very large wall where the word "welcome" is written in over 50 languages. There is a different stance if the hospital has all its signs only in one language, English, French, German, or any other "dominant language" in the country in question.

The policies of the work place may or may not facilitate providing that assistance to families who "come from elsewhere" or to whom the staff may not be used to deal with. This attitude is facilitated or thwarted by the people in the leadership of that clinical setting.

In many Western countries, increasingly clinicians who are originally from a foreign country, or who "look ethnic," may be asked to see patients that are "similar." In some hospitals, having a "Latino surname" may be sufficient to be asked to see most "Latino patients" indicating on the one hand the wish to help families feel comfortable, but also to avoid discomfort to other clinicians who may be unfamiliar with "those families." Also, in some settings co-workers may feel uneasy working with clinicians who are "ethnic" or colored. They may encourage everyone to "dress the same," i.e., as the dominant group, and not to show any individuality. A clinician in a very large medical center was asked to remove ornaments from his office because they "looked too ethnic," even though they did not reveal any religious or ideological biases. The clinician was encouraged to use a more "mainstream" decoration. A large pediatric hospital in an urban center had a policy of hiring mostly Caucasian physicians and prided itself in having "very few international medical graduates." This was not an openly stated policy, but one embraced in many centers in an unspoken trend.

In some centers or hospitals there is no interest whatsoever, in developing multicultural resources, materials in other languages or to make "foreign" people feel welcome. It is expected that all families "should be like us," or only a cosmetic minuscule investment is made in some resources, such as one interpreter, one or two "minority staff," and a minimal effort is made to communicate with those families. A true multicultural perspective may require greater efforts and to think of the experience of the families "in their own eyes." These differences between one center and the other convey important messages to the clients, as well as the staff.

Migratory Grief and the Ulysses Syndrome

The clinician should consider and investigate multiple contributing factors to a potential migratory grief. How long has the family been in their new home country? Are they somewhat adapting to their new environment or not at all? How much are they missing their country of origin? as well as take in consideration their age, sex, and country of origin.

Migrants are often exposed to very high levels of stress due to various factors. Symptoms like insomnia, migraines, anxiety, and irritability can all be aggravated by those factors contributing to what is described as Ulysses Syndrome. "The Ulysses Syndrome" (Diaz-Cuellar et al. 2013) refers to the psychosocial symptoms experienced by migrants who live in extreme situations. These symptoms are the response to the efforts of the migrant to adapt to contextual stressors.

Perceptions of the Clinicians

Families from very traditional cultures may have a very different view of what a therapist or psychiatrist is. In the Western world, as in the United States, most therapists or psychiatrists are considered "providers" which means that they offer a service, which is paid for by the family in general terms. The clinician is an "employee" of the family and mostly is at their service. They expect to contract with the provider for a service which the therapist provides. The family may decide to suspend this engagement at any time if they are dissatisfied with the work of the therapist and they take his or her views as suggestions. The family reserves the right not to follow any of the recommendations of the therapist. Families from traditional cultures may expect a more direct "prescription" or even "orders" from the doctors as it used to be decades ago in the Western world. The physician or therapist was seen as a person with high status and who had "authoritative knowledge" and was to be respected or honored. A very "consumer oriented" approach where all the decisions are left to the family may seem somewhat disconcerting for some families. In other cultures, there is a difference perception of the therapist. The health care worker may be seen more as an authority figure, a person with advanced education, an expert, and someone that "knows" how to deal with problems. The family is likely to try to follow the advice, which may be given in the form of a verbal prescription to do something. The family may feel disappointed if the therapist only invites the family to reflect, rather than offering practical suggestions about how to deal with a problem. The therapist in many countries, like a doctor may "order" or give a recommendation to a family to carry out certain actions and for the most part the family will follow it, if they trust the clinician.

In a recent encounter with a family of immigrants from Vietnam, the clinician pointed out to the mother of a child who had been born very premature and with multiple malformations, that she seemed sad. She had spoken of being irritable and fighting with her husband and of marital discord besides. When he pointed out that she seemed also very sad, the mother asked the psychiatrist if he was a "fortune-teller" that would know her thoughts from merely looking at her face, and whether he was going to give further advice. In Vietnam and China, as in many other countries people may go to a fortune-teller who through various devices can read what is happening with a family and give recommendations of a behavioral and psychological nature to help the family. This may include calendrical calculations, astrological ones, or looking at the shape of the ear of the adults to divine what is going to happen to them. A family might feel somewhat disappointed if the therapist does not answer certain questions as "not wanting to help them." Others may perceive the therapist as withdrawing useful suggestions, expecting he or she already knows things that have not been discussed yet. It would be useful to remember not to assume that the family has the same expectations as the clinician.

Many primary care physicians find that families of patients from traditional societies, be it pregnant women or with young children, expect something fairly concrete in terms of help from

the clinician. They may expect an injection, tablets, a physical treatment and not only an expectant observation or a conservative management. This may be felt by the family as begrudging things like vitamins, antibiotics, etc. which are expected even as preventive efforts.

Another “clash of cultures” occurs between treating physicians in highly urbanized hospitals and families from low income countries, who often come from rural settings. The doctor is seen often as rushed, spending very little time with the patient, and not involved enough to spend more time with the family.

Time and Schedules

Families who face multiple stressors or recently arrived in the host country might find it difficult to settle in an industrialized country and “enjoy the pregnancy” due to the worry about the baby. In these circumstances, with everything being so new, they may not realize that the adherence to the appointed time is not related to how nice the therapist is, or how flexible he is, but to “realities” and constrains regarding time. This reality exists in the mind of the therapist, who may have to adhere to a schedule and his or her institutional demands. A family may imagine that if the appointment is at 3:00 p.m., this does not literally mean that time on the clock but an approximate time. If they arrive around 3:15 and the therapist mentions they are late, they might feel rejected and never come back, or interpret that really the therapist “did not want” to see them. The fact that a session takes place or not is not perceived as a fact governed by time and the clock, but by interpersonal relationships, as it is common in most traditional societies.

This concept is even more true with immigrant families coming from countries where their expectation from the medical institution is very high or unrealistic. In some countries, people that are “well connected” have the ability to be seen by a doctor or clinician even on a very short notice and at a time that is convenient for them. When faced with this type of situation, a new expectation needs to be set but in a subtle and “gentle” way to avoid any tension between the family and the clinician.

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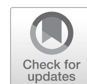

Culture-Bound Syndromes During Pregnancy and Early Childhood

20

Andrés Jiménez-Gómez and Sarat Munjuluri

The "Universality" of Culture-Bound Syndromes and of the Languages of Distress

These culture-bound conditions are relevant and included here for several reasons. One is a concrete one, i.e., if a clinician is faced with a family from a given foreign culture, it would be useful to have an awareness of the existence of these conditions as the family might think this is what is afflicting the pregnant woman (or the partner of the pregnant woman) or the young child. They might be afraid or embarrassed to say what they really think, because of the assumption that the clinician would not believe in such things or would consider them ignorant or superstitious. It is important for the clinician to realize these explanations are embraced by the family in question. Also, even very educated and sophisticated families invoke these culturally determined explanatory possibilities when they are faced with a condition that is difficult to treat or is severe or complicated.

Another reason, more abstract, to describe and characterize them is because of the themes that they represent, i.e., explanations that the public naturally and traditionally give for difficulties that are hard to manage or that may even lead to death. In this realm, rather than the concrete facts about the specific condition in one particular culture one might never encounter, the important issue is the mental representation for parents of what it means to have a "special" unique condition oneself or in one's child, and what are the causes and the possible remedies.

Third, we also include what one might call "culture-bound states" in very sophisticated and industrialized societies, such as attention deficit, oppositional defiant, and bipolar disorder in the very young child, which are frequently diagnosed and do not seem to be encountered as frequently in other social groups. This will allow us to put into perspective those "syndromes" that one may take for granted as "scientifically or evidence based," i.e., they exist in the real world or are universal. They might be the product or strongly determined by a cultural environment and parental beliefs, and practices rather than being "diseases" in themselves.

In all social groups, there are etiological explanations about why things happen, and this includes illnesses, odd behavior in a person, difficulties in a child, or a problem during pregnancy. Also, distress is expressed in different ways depending on the social group. In many cultures, the verbalization of

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emotions and internal states is less favored than a "body language" of distress, or the expression of suffering through somatic symptoms, such as tiredness, difficulty breathing, headaches, tingling sensations on the limbs, and chest tightness. These states are still very common even in cultures in which people "talk" about their internal states and distress, particularly when the style of the person or family is "not to verbalize" or even acknowledge to themselves forbidden or unpleasant feelings, such as sadness, rage, and fear. In many social groups in China and Japan, for instance, and among Native Americans in the United States, one is not encouraged to "talk about feelings" or verbalize how one feels. The feelings are inferred by others through facial behavior and attitudes, if they are perceived by others at all.

The culture-bound syndromes appear as socially acceptable ways of expressing that there is a problem, which is shared by others in the social group and which has a remedy that usually is also socially accepted.

There are multiple instances in which even when the cultural group encourages the verbal expression of feelings or internal states, certain expressions are unacceptable. Certain feelings and emotions should not be discussed with a husband or a parent, and the expression is possible only through the corporeity of the person (Nichter 1981). A corollary of this is that many of the culture-bound syndromes are psychosomatic in nature, and they have clear manifestations often through the body.

Folk Nosology vs. Scientific Nosology

In the area of emotional and behavioral difficulties in adults and children, including infants, there are multiple classifications or taxonomies of the various conditions. In the Western World, particularly in classifications like *DSM V*, one observes a "fragmentation" of manifestations of distress and symptoms to the point that the conditions have become numerous and some of them are actually symptoms or group of symptoms, rather than syndromes such as "trichotillomania" or "tic disorder." There are multiple reasons for this fragmentation, some of them having to do with reimbursement schemes and the strategies of insurance companies use not to pay for services. In response, clinicians have had to resort to a fragmentation of conditions in order to diagnose many of them in one child or adult and be reimbursed separately for the treatment of "each condition."

The Diagnostic and Statistical Manual of the American Psychiatric Association, as well as the International Classification of Diseases tenth edition, and others are mostly descriptive and more or less "a-theoretical." Their purpose is that clinicians should be able to agree on the manifestations of certain disorders, not of their possible etiology. The classifications are mostly non-etiological, except for conditions such as somatization disorders and posttraumatic stress disorder, or adjustment disorder. In contrast, the "folk classification" of conditions in cultures is precisely "etiological" in the sense that people explain the condition attributing it to specific causes. Folk healers attempt to diagnose where the disease came from: breaking of a taboo, envy, a vengeance, insults to ancestors, transgressions of dietary or behavioral rules, etc. People are interested usually in curing the condition "from its root" and efforts are made to remove the cause. The rules of thinking and "reality" are generally different, as the boundary between the worlds of magic and "reality" is permeable and blurred to our minds, and most people believe in the coexistence with ghosts, spirits, ancestors, witches, and the power of fetishes and other symbolic objects that may protect or harm. This might appear as very exotic, but one encounters similar beliefs in people in industrialized nations, who readily believe in the influence of the devil (in many Christian groups) as an agent who induces diseases, and the remedy is then to apply "prayer therapy" of one kind or another. There is also in those groups a persistent belief in the importance of penance, atonement, and even exorcism or "deliverance" as well, which in the Pentecostal Christian churches are fairly common in the present time (Hunt 1998). There is also a widespread belief in ghosts and spirits, even reincarnation of a dead relative in the body of a fetus. The "magical

thinking" is pervasive: when a baby is born premature or has some disease, parents often question if somehow the conditions is "their fault." In fact, a study in Africa finds that with modernization, the belief in bewitchment or sorcery is even more prevalent than before (Ivey and Myers 2008). We describe the following conditions not so much for their "exotism" or because they are unusual, instead because they reveal ways of thinking that are deeply rooted in the human psyche despite the superimposition of more "scientific thought," which often seems like a thin layer under which there are still many magical beliefs everywhere.

Another interesting question is whether such beliefs and their corresponding cures could indeed be helpful in alleviating the distress of parents and children and be effective within that frame of mind. One might question whether an exorcism in a charismatic Christian person might be an effective way of achieving relief.

It is necessary to reflect on the economical, material hardships that people endure in many countries, with poverty, high infant mortality, short life expectation, and multiple stressors in everyday life. In those circumstances and in order to survive psychologically and emotionally, adults often resort to the idea of "external dangers" lurking all the time to make a pregnancy turn out badly or cause the baby to be sick or die. These explanations are helpful to deal with the realities of everyday life which are quite harsh in much of the world compared with that of richer or industrialized nations (Scheper-Hughes 1984).

Why Study Culture-Bound Syndromes?

While the conditions described here may appear exotic and extremely rare, they are not that alien and certainly they are not rare. Many people from traditional societies are hesitant to invoke or bring up their ancestral explanations, theories, and true beliefs to physicians or other health professionals, as they may think the clinician will then they are superstitious or ignorant. They may expect they would be immediately dismissed as useless atavisms. The theories and healing strategies can only be revealed if there is a relationship of trust with the health caregiver.

If the individuals "make room" for the personal theories of individual and extended family members about their problems, why they think they are having such difficulties or what is really wrong, folk theories often emerge, as well as their previous attempts at curing them.

In learning about these conditions, one invokes themes that are universal. The clinician may need only to substitute one theme for another. We have encountered families in the United Sates that think that their child is "half alien," i.e., that the child has "half the DNA of a human and half the DNA of an alien," and the child's difficult behaviors are explained based on that hybridism. Also, many parents in the United States advance genetic theories about what is "wrong with their child" as being due to the bad genetic material of a parent that now is disliked or became adversarial after a divorce: the "bad genetic material" is attributed to the other family, the in-laws, and their negative characteristics.

A further reason to become familiar with these conditions is to incorporate families' own strategies for healing into the other "routine" interventions, be they in medical or in mental health. Trying to ignore them would merely convey to the family that their true beliefs cannot be discussed, which of course does not mean they will not be held or folk remedies will not be used. It seems better to discuss openly the patient's own strategies to help themselves and then make recommendations taking these into account. Some folk remedies might be detrimental, and it may be important to know about them. Also, assisting a family in multiple ways may be more realistic and ultimately more helpful than relying only on medications, which incidentally is another culturally based position on the part of the health professional.

Culture-Bound Conditions During Pregnancy

As noted before, in most cultures, pregnancy is considered at least as a "delicate state" in which

the woman requires special treatment: to eat properly or special foods and to be looked after by relatives and friends, often by other women mostly. The time is considered hazardous because many things can happen.

Describing culture-bound phenomena is difficult because often these conditions are described "loosely" by different informants, and even when using the same name for them, like "*nervios*" (nerves or nervousness in Spanish). The term might have different meanings and boundaries in various cultures.

In addition to the "specific" pregnancy-related conditions mentioned here, a parallel may be drawn between some of these states in the adult or pregnant woman, and psychosomatic conditions, somatoform disorders or conversion disorders, previously comprehended under the term "hysterical phenomena." Conditions that may symbolize an internal conflict or a traumatic memory in the woman may appear as a somatic condition for which no medical cause can be found, such as pseudo-seizures, astasia-abasia, fainting or temporary loss of consciousness, and unexplained pains and sensations.

The Vicissitudes of Pregnancy in Their Cultural Framework

The social status of women in most human groups is lower than that of men, in some societies it is limited to becoming a housewife, tending to the home, the children and the husband, at times additional relatives, and hardly going out of the house (Nichter 1981). To give an example, Havik women in South India (who are usually Brahmins) traditionally were raised to become subservient to their husbands and the husband's parents. Indeed, adult women were considered to be "child-like" even as adults, therefore requiring guidance and protection. During child rearing, values such as compliance, obedience, silencing her own emotions, and not expressing discontent are strongly emphasized by the parents, in order to prepare the girl to be a good wife. These themes, in lesser or marked form still resonate for the condition of women in most of the world, even in industrialized societies, although in subtler ways. Girls are often socialized to be kind, to smile, to not express discontent, and to be very compliant, almost to guess what other people want them to do or prefer. In these circumstances, it is not surprising that women may encounter additional difficulties when they are going through the rigors and stresses of a pregnancy, which may or may not have been sought, and which may be expected of her, in order to produce children and to be a good mother.

Contrary to the common thinking in industrialized societies, in which a woman is either pregnant or not, in other cultures pregnancies have several further destinies. One can be "partially pregnant' or have the "beginning of a pregnancy." It is not even necessarily established that sexual intercourse is absolutely the cause of a pregnancy. Also, a fetus may decide not to continue growing. The pregnancy may also "go to sleep" and be delayed, which is a folk belief among the Hausa (one of the largest ethnic groups in Africa) and in Morocco (Last 2004).

Unusual Dreams

In the "Westernized world," there is little research as to the common dreams that occur in women who are expecting a baby or those of their spouses (Mageo 2011). Many women anecdotally report dreams in which they see themselves having the baby, going to hospital, embracing the child, etc. At times, there are nightmares in which the pregnancy has a negative outcome, reflecting common fears of women and men during this vulnerable period, such as a complication, premature birth, or the death of the baby.

In many traditional societies, the dreams of women may be considered as "diagnostic" of a condition. For instance, in some women in Nigeria, dreaming with water, being underwater or about mermaids is considered as a possible sign of a possession by spirits, such as one of a mermaid. Other dreams are considered "premonitory" and may include dreams of something breaking, of being lost in the woods or being kidnapped. Dreams are taken very seriously in many cultures and are seen as a way of communicating

emotional distress or fears that something may go wrong during the pregnancy.

Partial Pregnancy, Stopped Pregnancy, Pregnancy with Puppies

These conditions are not seen frequently in clinical work in perinatal mental health, and they are mentioned because they are helpful to illustrate the "irrationality" that can accompany beliefs about pregnancy and which is partially rooted in spiritual and religious beliefs. The notion that one is pregnant or not pregnant is apparently quite simple, but still in various cultures women may think they are just "partially pregnant" or that they have the "rudiments of a pregnancy" which could progress to a full one or regress into a regular state without expecting a baby. The absolutes that are common in a Western mind may not apply in all cultures. The same can be said of a pregnancy that "stops" and is "dormant" so to speak, not moving forward nor regressing. In Haiti there is a culture-bound condition called *pedysion*, which describes a syndrome of arrested pregnancy: the woman starts with a normal pregnancy, which is interrupted and arrested. The woman may continue to believe she is pregnant, and the process may last months or even years, until cured by a folk healer (World Health Organization 2010). It is thought that the woman then "is pregnant" which may be an important consideration in evaluating her capacity as a wife and future mother, in a culture where this might be an essential woman's role (Coreil et al. 1996).

In some areas of India, particularly in the Bengal area, a condition was described of pregnancy with puppies (Chowdhury et al. 2003; Simon et al. 2009). It can affect both men and women: a man may develop the strong belief, shared by many other community members, that he is pregnant with puppies after being bitten or attacked by a dog. The authors suggest that after the incident, there is a social pressure to consider the possibility of a pregnancy with puppies. In one described case, witnesses assured that they "saw that a boy vomited a dog embryo." Although this may appear extreme, in many other areas of the world, a woman may be convinced she is pregnant without being so. In some cases of pseudocyesis, we have encountered the belief in a woman who is convinced that she is expecting a baby (and develops many of the bodily changes associated with pregnancy, but there is no baby in utero) that despite the "evidence" of laboratory studies and ultrasounds, she may suspect that something is wrong with the studies, or a collusion is taking place. In some cases, the woman continues to claim she is pregnant for well over 9 months and explains this as "God's will." This is seen mostly in situations in which a woman ardently desires to have another baby perhaps to please her husband, her extended family, or to fulfill her wish to have a boy or a girl.

Pregnancy with the Spirit of an Ancestor

In our clinical work, in the United States and with educated or sophisticated women, we have encountered multiple instances of a pregnant woman thinking that the baby she carries is the "reincarnation of the spirit' of a dead relative, such as a brother, a sister, a grandparent, or even a friend. This is most often seen when the person died shortly before the pregnancy or during it, and was very important for the woman who is now expecting a baby. She may name the baby after that dear person, or with a derivative of the name, and be convinced that the child is a compensation from God for her loss. The lost spirit that went to heaven seeks to reappear in a "new opportunity" and to stay with the beloved person (the pregnant woman). This can also be seen after a perinatal loss in which the woman is convinced that the spirit of the baby who died has reincarnated in the form of the new baby she carries now in utero.

Possession by Spirits

The phenomenology of possession of the body of a person by the spirit of an ancestor, an evil spirit, or a "*jinnie*" or a "*lantuch*" exists in many cultures

throughout the world and is seen in everyday life, even in highly industrialized societies, although less frequently there.

While this is not a state unique to pregnancy, in various cultures, the condition of being pregnant is thought to make the woman more susceptible to many kinds of difficulties. A pregnancy may be a "duty," a mandate, and an ardently desired event, and it is full of uncertainties as to its progress and final outcome the production of the "right" infant; however, this is defined in that particular group. In some groups women are particularly susceptible, and many anthropological studies see these states as a manifestation of conflict in the affected woman, which may manifest as a sudden attack of possession, for instance, falling to the floor, screaming, and becoming uncontrollable in some Malaysian women (Ong 1988), and in that context, it is a culturally sanctioned way of "protesting" or revealing the discontent with her condition. This resonates with the "psychopathology" that one observes in the Western world in other ways, such as somatization, dissociation, and unexplained pain, or excessive complains during pregnancy (Maldonado-Duran et al. 2000) and which may be related to a stressful situation in which the woman finds herself, trapped, maltreated, frightened, etc. In the case of some Malayan women, the possession is considered a "disease of the soul" (*jiwa*) which might be a more appropriate way of describing the state than "hysterical attacks." These phenomena in traditional societies have also been linked to the rapid social change, disrupting the traditional social structures and the introduction of factory work with its expectations and rules for many young women, whose labor is cheaper. In Malaysia, traditionally, these states used to be treated by folk healer or *bomoh*. The *bomoh* tends to remedy the problems by readjusting the relationship between the human and the spirits, who attack when the person has committed some moral transgression. Women are traditionally considered more prone to transgressions due to their "erotic" nature, their more "polluted" bodies and their higher emotionality compared with men.

In many cultural groups, careful rituals are performed during childbirth in order to keep away evil spirits. If the recently delivered woman is possessed by a spirit, she may lay down, and not be interested in the baby or in nursing. Women are often considered impure during delivery, due to the release of blood (like during menstruation), and items related to the blood or the impure body such as pads, rags, nails, and hair can be also used for "black magic."

In many cultures, including those with Islamic influence, the spirits are disembodied beings that can violate the boundaries between the material and the supernatural world, they have different rules and represent the transgressing of important moral rules. Additionally, in some areas of Malaysia, mostly formally Moslem in religion, there is a particular spirit called *pontianak*, which is the spirit of a woman who died during childbirth, and which threatens women who have just delivered and her newborn baby (Ong 1988).

Devaki Syndrome

This condition is mentioned as an example of a response to repeated miscarriages (Nath et al. 2015). In a culture in which a central role of women is to have children, carrying the pregnancy to term is a triumph, and conversely, repeated failed pregnancies or the inability to have a baby can lead to ostracism and social disapproval as if somehow she were to blame for something from her past. Having repeated losses may be particularly traumatic. In the *Devaki* state, the woman who has had previous miscarriages and is pregnant now develops intense fears of another loss, starts having insomnia, depressive feelings, anxiety and fears of another loss, and foreboding thoughts and dreams. She may surround herself with pictures of Lord Krishna (the son of Queen Devaki in Hindu mythology) who became a god. She may see herself as a victim much like Devaki, who had had seven previous losses (the newborns killed by the king who feared that the baby would eventually kill him) and eventually she manages to have an eighth child who is Lord Krishna. The essence of the

condition is the fears of loss, the importance of motherhood, and the identification with the victim role and the fear of external circumstances "killing her babies." The woman may benefit from supportive psychotherapy and religious invocations.

Effects of Eclipses and Breaking of Taboos

Having a child with a malformation, such as cleft lip or palate, is considered a negative event in most cultures. In some it may be seen as a reflection of some guilt or bad deed on the part of the mother or the father of the baby, which may reflect poorly on the whole family. However, another explanation invoked frequently, for instance, in many families in Mexico and in many cultures, is to "externalize the blame" and attribute it to the effects of an eclipse. Eclipses were considered ominous in many cultures in the past, particularly a solar eclipse in which the day becomes dark for several minutes, or when it appears that the moon is disappearing for some brief period of time (lunar eclipse). Women are advised not to go outside during an eclipse when they are pregnant. In order to protect themselves, many women who espouse traditional beliefs would use a piece of metal around the waist in order to ward off the effects of an eclipse to which they might be inadvertently exposed. At times clinicians in obstetric units wonder about the meaning of a key or another piece of metal that the woman brings tied with a string around her abdomen. Blaming eclipses may be a form of not considering oneself as guilty of having produced a "marked child."

Coraje, Hwa-Byung, Susto, and "Nervios"

Coraje (meaning rage or anger) and *muina* (an angering experience) are commonly avoided in many countries, for instance, in Latin America. A woman who has a sudden experience of anger, for instance, in a fight with a neighbor or with a rival woman, may fear that the pregnancy will be ruined and the anger she experienced might lead to a negative outcome. Women then are often "protected" by their families from news or events that might provoke such an intense emotion of anger, which may take time to be processed and may impact the pregnancy very negatively.

A similar condition described in Korea is called Hwa-Byung (Min 2013) which consists of repressed anger in the woman but is not exclusive to pregnancy. It often occurs in situations of domestic abuse by a husband or a mother-in-law and perceived unfair treatment. The woman is unable to express her rage openly, and the anger is somatized in the form of a feeling of oppression in the abdomen which comes to the chest, a feeling of heat inside one that pushes to come out, depressive feelings and anxiety states (Kim et al. 2010). Repressed anger, given the condition of oppression of many women in very male-dominated cultures, or when one is subject to the wishes of a mother-in-law who may not be supportive, or when one is bound to obedience, should be considered as a central concern for clinicians dealing with women with the symptoms of "repressed anger" mentioned above.

Susto (or *espanto*) is a similar construction but with more ominous representations. Susto literally means fright, and it can affect anyone, but expecting women and young children are particularly vulnerable to *susto*. Among the Quechua indigenous community in Peru, it is called *manchariska*. It is also diagnosed in the Mediterranean world, in Southern Italy, it is referred to as *scantu* or *guasto* (Gallini 1992). In the French Caribbean cultures, fright also occurs and is called *sésima or seizisman* (the original word in French for fright is saissement) (Quinlan 2010), *narahati* in Iran (Good and Good 1982), but it exists in many other cultures. In this state of fright, the soul of the person leaves the body. In the woman, she may become very fidgety, restless, anxious, develop insomnia, and constant anguish after witnessing a scary event, a fight, experiencing a fall, an accident, etc. which might have frightened her suddenly. The diagnosis is suspected by the family and confirmed by a healer or curandero, or by a knowledgeable grandmother or aunt.

The remedies vary but may involve cleansing vapor baths, body massage, prayers, and "cleansing" with herbs to make the spirit return and give rest to the woman.

Cansancio and Move San

Move san (the folk name of what in French would be written as *mauvaise sang* or "bad blood") is another example of mind–body interaction, and it is a common condition in Haiti (World Health Organization 2010) and obviously among immigrants from Haiti to other countries. This is a state of constant anxiety, nervousness, or depressive feelings associated with a frightening experience during lactation, which leads to the milk being, so to speak, contaminated with ill humors and can affect the baby adversely, the baby will become irritable and not sleep well. The theory is that the moods of the mother and her experiences reflect on the quality of the breastmilk. The milk can be referred to as "*let gate*" (lait gâté or ruined milk). The boundary between the mind and the body is very fluid, and one affects the other. A related concept is *let tounen*, which literally means turned milk and signifies the ruination of the milk when the lactating mother becomes pregnant with another baby, and it is thought that if she keeps breastfeeding the already born baby, this can make him ill. The remedy for the mother usually requires preparations of herbs. *Move san* sometimes is thought to kill the affected woman if not treated properly. At times the move san and let gate are given by mothers as a reason to discontinue breastfeeding early, which in the conditions of great poverty prevailing there may lead to malnutrition in the infant. Some experts consider move san as a response to very difficult circumstances, chronic stress, constant worry about survival, or economic deprivation, and in this sense, it is of interest as a manifestation of the social milieu manifested as a "folk illness." This is an important lesson as many women (and men) all over the world manifest their distress and worry with a variety of psychosomatic conditions that reflect those socioeconomical circumstances, rather than just magical beliefs or individual features (Farmer 1988). *Cansancio* which means exhaustion or tiredness is diagnosed in a number of cultures in South America. It often designates mothers who have had several children and their body (and soul) show signs of exhaustion, of too much exertion and use, and the woman appears dejected, with diminished energy and depressed. It is thought mostly a sign of accumulated pregnancies, each of which takes a toll on the body, as though there were a finite amount of energy that is "spent" (Lopez-Austin 2004) toward the end of the reproductive life of the woman. The phenomenon is not temporary, and the woman is thought to deserve special considerations and reverence due to the effects of all her labors.

A similar clinical picture has been described in an area of Tanzania, but which may have universal application. It is called *Baridi* (Juntunen 2005) and consist of a state of coldness, tiredness, and nervousness. It affects mostly women. It can be associated with diminished appetite and loss of weight. The issue is that it is a sort of punishment for transgressions such as speaking ill of one's parents or elders, being disobedient, or neglecting her duties. It can also occur from parents coursing the person. The remedy is to apologize and to atone, public confession, and herbal remedies.

Couvade or "Male Pregnancy"

This syndrome is encountered in many cultures, in traditional and modern societies. It can be described as the spouse of a pregnant woman, or the biological father of the future child, to develop symptoms of pregnancy, often similar to the ones in his wife or partner. These can include increased appetite, weight gain, cravings, nausea and vomiting, mild breast enlargement, even back pains, sleep alterations, and in the traditional description, cramps and pains during the wife's labor (Breeban et al. 2007).

Cox (1979) studied a traditional postpartum condition, a form of "postpartum psychosis" in a group of cases in Uganda, known as *Amakiro*, and one of its manifestations is the persistent wish of the mother to eat her baby. Little is known

about other features, people interviewed and acknowledged it readily in the study, and it was thought to be due to having been promiscuous in the past and not having taken the customary herbal baths during the pregnancy. Incidentally, the wish to eat the baby has been described as an unconscious one in the Western literature and usually sublimated and not expressed directly.

Some Conditions During Infancy and Early Childhood and Their Remedies

Mamitis and Being "Chipil"

This is a state of being irritable, crying easily, and being easily annoyed and demanding in the infant. It can be caused by multiple phenomena. A child is considered "*chipil*," irritable and demanding, when the mother is pregnant with the next baby and the infants senses a threat to his or her importance in the family as "the baby." Also, it can be the result of foods, air, evil looks, envy, and other multiple causes, it is an ill-defined state, but a very frequent one when the child is prone to crying. *Mamitis* refers to a similar neediness, irritability, and clinging of the infant to his or her mother, particularly as a toddler. It is thought to be the result of being "too sensitive" to the needs of the child and making the child spoiled, too dependent, and anxious (Gutmann 1998).

Larpha

Larpha is a construction that is common among the Aymara native population in Bolivia and Peru (Michaux 2004), as an explanation for malnutrition in the baby (Castillo-Carniglia et al. 2010). It is considered to be a mystical condition, usually a reflection of a transgression by omission or commission on the part of the baby's mother. One of the causes can be that the mother is exposed to bad odors from dead people, or a dead dog or cat in the street, it can affect pregnant women or the baby between birth and 6 months usually. It is a sort of punishment for her behavior, which reflects poorly on the mother and her family. The remedies are also mystical and uncertain in terms of recovery. The malnutrition of the baby is not considered the result of poor ingestion of food. Often, it is compounded by the perception that the child "is that way," naturally, and that this is his or her nature.

Mal de ojo (evil eye)

Mal de ojo or "evil eye" is a condition that is acknowledged in many cultures and countries, certainly in the Muslim and Middle Eastern World, in Mediterranean cultures, and all of Latin America. Generally, there is a fear of the "heavy eyesight" of a person, who possesses such a quality and looks intently, insistently, admiringly or with longing at a "vulnerable" person, who could be an infant, young child (or a pregnant woman). The person with "heavy eyesight' may not really have evil intentions but be too admiring or to flattering of the beauty of a child, for instance. A frequent element is a feeling of envy elicited in the admirer, who looks at the other wishing the child was his or hers or feeling envy that one does not have a child like that (or envying the pregnancy). So the damage may be unwitting, or due to intense envy and anger at the happiness or fortune of the other person. The affected baby may develop diarrhea, irritability, fever, a respiratory infection, or just sleeplessness or become sad and tearful for no obvious reason for an extended period of time.

In a recent encounter, the mother of an infant from Honduras, described her relief when a nurse touched her baby's head to ward off the evil eye. She had been admiring the baby. The mother explained her conviction that evil eye is real and that she has known of cases in which children have become seriously ill or have died from it. She explained she usually dons her baby with a red bracelet to protect him or red beads around his neck. Asked why she did not put them on the baby that day, she said she feared being criticized and in her previous contacts with nurses they always looked down on that and "took it off anyway." There are multiple protective devices, like seeds

with the shape of an eye (*ojo de venado*), deer's eye seed in Mexico, blue items, Fatima's hand, or beads with the shape of an eye. Once the damage has been done, there are strategies of "cleansing' the evil eye, in Latin America in many groups with herbs, prayers, and with an egg passed around the body of the child or being exposed to smoke from incense or copal.

Tokolossi (or the Bewitchment of Small Children)

There are several names for these beings, including Tikoloshe, Tokoloche, and others. The belief is prevalent in South African groups such as the Bantu, the Zulu, and the Xhosa, among others. Tokolossis are thought to be invisible imps or evil spirits that can cause damages to multiple people, including young children (Niehaus 2001; Schmidt 1984). They may manifest as bruises or needles inserted on the baby's skin. They are water spirits that seek to damage people. In some Latin American countries, bruises in the baby can be ascribed to the effects of witches sucking on the skin of babies or young children, and the belief in witches is widespread across the world still (Ally 2015). An important issue is that a young child might have a medical condition that is misattributed to witches, this attribution might delay important medical diagnostic or treatment efforts. Also, child abuse can be disguised as the effects of witches.

Oppositional Defiant Disorder, Attention Deficit, and Bipolar Disorder in Preschool Children

In the United States there has been a development during the past 15 years or so, in which even very young children are diagnosed by members of the medical profession and other caregivers (teachers, counselors, etc.) as having a variety of behavioral disorders, and not rarely more than one of them. The most common are related to "disruptive behavior" in the classroom or at home. A particular concern is the ascendancy in frequency of "bipolar disorder," as well as the others, which are diagnosed only by "diagnostic criteria" often based on the parental report or the teacher's report of the child's external behavior. Issues of stress, exposure to difficult circumstances, and stress are often not inquired about by very busy physicians who have limited time to explore in depth. This has been called the "medicalization" of children's problematic behavior (Healy and Le Noury 2007). In the culture predominant in the United States, it is considered that these are brain dysfunctions, and very often one of the first interventions is to resort of pharmacological treatment to "correct" the disorder or imbalance, often as a matter of course (Moncrieff 2014). A complete description of the nosological status and the purely (or not) culture bound nature of the disorder is not discussed here. Our emphasis is on the fact that the construction of these entities as "psychiatric disorders" entirely based on brain malfunction and genes fails to take into account the complexity of the transactional nature of children's lives and functioning. For instance, the emphasis on obedience and compliance in many preschool settings may lead to the perception that many more children might have these conditions. It is not so rare to hear parents who have very active children to refer to them as having a number of letters: "he has ADHD, ODD, and BD" (he has attention deficit hyperactivity disorder, oppositional defiant disorder, and bipolar disorder). Furthermore, at least the attention deficit issue is often left for the pediatrician to treat, a professional that in the United States has very limited time to spend with each family, and averaging around 8 min per patient in many pediatric settings. Increasingly parents accept these diagnoses and the consequent pharmacological treatment as any other medical disorder, like diabetes. While there is little doubt that these conditions exist in the real world, even in young children, they might be much more rare than it is presently diagnosed. This trend is also becoming more prevalent in Europe. Increasingly child psychiatrists are trained mostly as pharmacotherapists, having little else to offer in terms of treatment, this includes "mood stabilizers" and antipsychotics (Olfson et al. 2006). An additional cultural feature is that there are multiple "diag-

nostic questionnaires" to diagnose bipolar disorders available in the Internet.

Doenza a crianza

Doenza a crianza (in Portuguese, a sick child) is a condition described in detail by Scheper-Hughes (Scheper-Hughes 1984) in North East rural Brazil, but it is mentioned here because "variations" of it can be seen in many parts of the world including industrialized countries. The essential features are that a mother may perceive her baby as "defective" or week, or "not wanting to live" or not having enough vitality and then selectively neglect the infant. An important element is that such a mother is usually very poor, works very hard, and tends to several other small children. If the mother (or neighbors) concludes that the child has this unwillingness to stay in the world, they will care minimally for the child, who eventually becomes sicker and may die. The researcher was impressed that the mother showed very little outward sadness after the death of the baby, who then is considered an "*angelito*" (little angel) destined by divine forces not to stay in this world but designated as a baby by God. In other forms, it can be seen in any family that is burdened with many problems, poverty, several small children, and has an infant who has too many health problems and she lets "nature take its course" without heroic measures. The notion is that in severe scarcity of resources and an overtaxed mother, this response is understandable.

Abiku and Ogbange

The conditions can also be referred to as "mami wata" (Ilechukwu 1990), and it has been described mostly in Nigeria, among the Igbo and the Yoruba, Abiku among the Yoruba and Ogbange in the Igbo, but the belief is common in West African countries. Families may be reluctant to describe their belief in this, but a recent survey revealed that a majority of people interviewed in a village believe in the existence of *abiku* children and in the folk remedies corresponding to it (Ogunjuyigbe 2004). The theme is a universal one. The child is born with special characteristics that are undesirable, like irritability, malformations, too dark skin, frequent illnesses and is thought to be lured by evil spirits to "go back" to the world of evil spirits. The baby is treated in a special way in order to fight to "stay in this world." The parents may give the child special foods, more food than other children, and ensure that their child does not cry and does not get upset. Parents may give the child a special name to fool the spirits or to entice the child to stay. In the case of infant death, it is attributed to that struggle in which the evil spirits have prevailed (Ogunjuyigbe 2004). It could consist of a strategy to explain the death of a child which is due to pervasive external evil influences that must be warded off as much as possible. Generally, the solution is to first take the child to the home of a traditional healer and, if this fails, to a medical facility.

Evil Eye, Envy, and Witchcraft

Probably in most cultures, this is particularly true in conditions of poverty, scarcity of resources, and less emphasis on privacy; envy is a constant risk. Families are careful to not boast of their good luck or, if they acquired something special, are particularly lucky or obtained a benefit, because other people around them might experience envy. In the perinatal period, the main risks are the sheer fact of having become pregnant, and later on, if a baby is a boy, or is particularly beautiful, has desirable physical features, etc., the mother would be careful never to "brag" about the beauty of the baby and instead might want to say something negative about her baby to neighbors and other people around her. She might focus on pointing out an undesirable feature or minimize her happiness at least. Otherwise, she may elicit the "evil eye" particularly toward the baby. If another person looks intently at the baby and experiences baby, or the person has "heavy eyesight," she might worry the baby will fall ill, develop sleeping problems, and excessive crying, if not a worse disease. Such a mother might ward off the evil eye with a gesture, or perhaps "cleans-

ing the baby" as soon as they get home. Health care personnel might be wise not to flatter the baby too much, or the mother in their congratulation, and might avoid looking at the baby too long. The mother, depending on the culture, might tie an amulet about the baby's wrist, or the neck. This belief is widespread in Latin America, the Middle East, the Mediterranean world, and many countries in Asia (Ember and Ember 2004). Overall, this construction might imply that not only are not mind and body not separated, but that one can become sick from interpersonal relationships. That is, the feelings of others can make one sick, which is another etiological conception bound to cultures.

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21 Use of Traditional and Folk Remedies and Traditional Therapeutic Strategies

Andrés Jiménez-Gómez and Sarat Munjuluri

Use of Traditional and Folk Remedies

The Use of Folk Remedies and Traditional Therapeutic Strategies

> *Sometimes I have thought that some traditional healers are more effective than the best doctors*
> Mahatma Gandhi

Why Traditional Healing Strategies and Healers?

Traditional and sometimes "magical" remedies are used everywhere. Even in industrialized countries with a highly sophisticated medical establishment, those services coexist with the "cures" and therapeutic strategies that have been utilized for centuries. Indeed, the distinction between spiritual-magical interventions and purely "physical" remedies has been in place for only a few centuries. Physicians in Egypt and Greece thought that in addition to the medicines that a patient could take, interventions such as baths, massages, and psychological well-being were part of the cures they recommended. In Europe, when people experienced a "nervous crisis" or devastating state of mind, they went to a "cure" and remained in those facilities for several weeks or months. Even in the nineteenth century and the beginning of the twentieth, there were multiple establishments—sanatoria—that we might nowadays consider "spas" or sanitary institutions where people could go to get a "rest cure" in addition to a special diet, baths, massages, electrotherapies, psychotherapy, etc. (Moses and Hirschmueller 2004). These cures were recommended for a variety of conditions from purely physical ones to "exhaustion" or neurasthenia, *surmenage*, anxiety states, and other emotional conditions.

The Western distinction between mind and body is not part of the belief system of people in most traditional societies. The unity of mind and body is being "rediscovered" in industrialized countries, in which it has been acknowledged that the state of mind of the patient influences his or her response to stress, to noxious agents, and has an impact on the immune system. There is also increasing information about epigenetic phenomena, in which events in the person's life lead to the expression or suppression of the expression of genetic material, altering the functioning of

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the body in ways leading to diverse health outcomes (Lupien et al. 2009).

Such a unity between the emotional/mental/spiritual states of the individual and the status of the physical body, its functioning, and its alterations (pains, weakness, malfunctions) is part of the belief system of people in most non-industrialized countries, where the traditional healing interventions may coexist with the latest medical innovations and technologies.

In traditional cultures, in which the body manifests emotions, or there is an intense embodiment of the self, or distress is manifested in bodily sensations (Seligman 2010), therapeutic strategies that focus intensely on the body might be particularly useful.

The belief in the supernatural and spiritual element is part of the heritage of most cultures and has not been abandoned. Even in modern societies, there are therapeutic strategies such as "praying therapy" used by some Christian believers (O'Connor et al. 2005), with children and adults when they are affected by a variety of conditions. In the United States and Europe, telephone services and radio and television programs exist in which a psychic portends to read—at a distance—the subject's situation and suggests remedies or actions to solve a problem, often such problem is of an emotional nature. Government leaders and officials in various countries have consulted these psychics at times of difficulty to obtain advice and suggestions on how to proceed even on world affairs. Even though these services might be considered as superstitions of "backwards," they illustrate that when people find themselves in a very difficult situation, they often resort to all means possible, including magical beliefs, to try to alleviate it. Why do these therapeutic services persist?

1. The traditional diagnostic and therapeutic strategies are inherited from one generation to the next and they are often recommended by elders and the previous generations as the first line of intervention because of the belief in their efficacy and because they fit in their particular worldview and explanations as to the origin of the malady or alteration.
2. Such "healing services" tend to be more accessible: for instance, in rural areas where a medical center would be hard to reach; and they are also often more economically feasible. Many interventions are implemented by elderly men or women, other relatives or neighbors, often at no charge. At other times, a "specialized healer" could be consulted, such as a shaman, a "curandero," or "witch doctor" (male or female) who may or may not charge, and may expect to be compensated by voluntary contribution or in exchange for some material good or service. Families in many poor countries may prefer to use these services as the first line of intervention to avoid the costs of large medical bills and hospitalization.
3. Even in modern countries, when the most advanced medical knowledge and interventions are unable to cure a condition, people resort to this "alternative healing system" to diagnose the condition and to get advice on how to improve it. This might apply for instance with cancer when given a bad prognosis or a sense of intractability by a medical service. Individuals are compelled, for example, to drink water from the Lourdes religious site, located in France, in hopes of getting a different result, to perform a pilgrimage, a religious promise in exchange for a miracle, or to use traditional remedies—often with the hope of complete cure.
4. In the case of primarily emotional problems (such as pervasive sadness, fears, or other psychic disturbance), mental health specialists are hard to access in many parts of the world and mental health interventions are implemented by teachers, priests, other religious leaders, older men or women and at the most, by general physicians. Psychiatrists and psychotherapists are just not available in many areas, even if one could afford their services.

One should not embrace an idealized view of traditional healing practices as completely innocuous and without perils. Some herbal remedies applied to infants and to pregnant women may be dangerous, as well as some healing procedures, like

moxibustion or "coining" (applying a heated coin over a person's skin) which can cause burns, which at times can be misconstrued as a form of child maltreatment. Also, with some diseases, if caregivers were to rely only on traditional medicine, this might delay other diagnostic or therapeutic maneuvers that might be necessary or more effective. A baby who suffers from fever, a rigid neck, and cries intensely may well have meningitis and require prompt treatment with antibiotics. Delaying such treatment may have negative consequences for the baby. Fortunately, many shamans and healers are aware of limitations and may refer the patient–family to the medical establishment.

The clinician ought to have some familiarity with the main "curing strategies" used in different cultural groups. It would be impossible to give a complete catalogue of all of them. We focus on the ones that a Western clinician is more likely to encounter locally and in working with immigrant clientele from various parts of the world. Also, the concrete remedies may differ, but some general principles apply to most of them.

Healers, Shamans, or Traditional Helpers

In most cultures, the healer has to have a special status and be recognized as such in order to inspire confidence in the patient or family. He or she must portray confidence in his or her abilities in order to make convincing diagnoses and prescribe remedies.

It is clear also that the diagnoses given by the healers may refer to culture-bound conditions, or to states that are a combination of alteration in the mind, body, and "spirit" at the same time. For instance, the diagnosis may be "susto" (fright, with many other names in different countries, like *Mancharisga* in Bolivia), "*nervios*" (nerves or anxiety), or "*aire*" (air) to explain the entrance of air in the bones, the ears, the head, etc. The fear of cold drafts is quite pervasive across traditional cultures all over the world, as it was in Europe in previous centuries.

Oftentimes, a corporal symptom (pain, stiffness, redness, etc.) are the cause of the consult, but not always. The main reason may be sadness, tiredness, anxiety, multiple fears, or insomnia. At times, the patient is thought not to have a "true disease" originating in his/her own body, as opposed to an "imposed disease" (*mal puesto* in Spanish), i.e., the result of witchcraft, voodoo, or envy. In this case, the disease comes from an external source, and from the negative feelings of other people toward the affected patient (anger, jealousy, resentment, envy) which have magically caused the symptoms in the victim. The remedy consists of protecting the object of the evil wishes and extracting the negative influence that penetrated the body (Organization Panamericana de la Salud 1999). Other diagnostic categories such as being "sucked on by witches" (*chupada de bruja* in Spanish) and possession by spirits may not be caused or desired by another person. They may be the result of being in a vulnerable state (as in pregnancy or being a baby), due to some transgression or a punishment for a misdeed, or a fortuitous event (like accidentally seeing a corpse, or being frightened by a fight), which may make the spirit particularly weak.

At times, the healer acquires expertise through long training under a mentor who reveals the nature of the conditions and medicines. In some cultures, the healer is a member of a family of healers and inherits knowledge that is transmitted from one generation to the next. Other healers might have a "special gift" conferred upon them by higher powers—for instance, to be able to perceive spirits, ancestors, or to communicate with the "other world." They can do so on demand, through special rituals, and in some cases by consuming beverages such as alcohol, hallucinogenic substances (*ayahuasca*, *peyote*, hallucinogenic mushrooms, etc.) which permit the healer to open a "bridge" between this world and what is beyond.

In other examples, the healer diagnoses the patient by passing an egg or another item over the patient's body and then diagnoses the condition by inspecting the egg or analyzing the way coffee beans fell, or how coca leaves distribute themselves on the ground. Intuition and experience are paramount in these professions. Communicating an authoritative diagnosis and therapy advice is also essential in the psychosomatic act of healing.

We include a few traditional remedies which are used during the perinatal period and early childhood, some of which could be dangerous. There is an increasing trend in the West among families afraid of chemicals from medication companies, thinking that herbal medicines are uniformly harmless because they are "natural remedies." Some concerning ones are mentioned in the manner of illustration of the need to be vigilant.

Herbal Healing

At the borderland between magic and "natural healing" is the use of various sorts of herbs that have been used all over the world for thousands of years for various disorders. Some of them are indeed curative agents, and some have "magical properties" and do not cure directly (by being placed on the body in cataplasms, ingested, made into capsules, etc.) but through their symbolic value. Some flowers are used because of their color: red for instance symbolizes heat, energy, fire, and strength. Other colors may stand for other qualities or protections. Among the beverages are the various infusions such as chamomile tea [*Matricaria recutita*]. In the postpartum period, remedies are used to promote the production of milk and breastfeeding, and for the woman to recuperate her strength and endure the rigors of caregiving for a small infant, anise tea [*Pimpinella anisum*] and fennel tea [*Foeniculum vulgare*] are drinks that are thought to soothe the digestive system in small children and pregnant women.

The Main Schools of Healing Used in Traditional Societies

Santeria, Candomblé, Voodoo, and Related Systems

These include a "system" that is really an assemblage of beliefs and practices that are used particularly in the Americas and are a "hybrid" of ancient traditions from Africa that migrated with the slave trade from West Africa to the West Indies (Caribbean and Latin America) and the United States. These beliefs were admixed with European and indigenous systems in the different regions.

With the slaves from Africa also arrived their religious beliefs, and the Gods also migrated. As the colonization from Spain, Brazil, France, and Britain in the Americas was already in progress, the Christian beliefs were hybridized with the ones brought from Africa, leading to the syncretic system in which for instance the Christian saints adopted the names of old African Gods and their powers. Saint Francis of Assisi became *Orula*, Saint Barbara became *Shango*, Saint Peter turned into *Ogun*; *Yemaya* is one of the names of Virgin Mary, just to name a few. These saints are more or less equivalent to Gods, although formally they are considered only saints. In *Candomblé*, practiced predominantly in Brazil, there is a central God (*Oludumaré*), and his assistants (*Orixas*), who are lesser gods. Each human, even a child, is "governed" by a specific Orixa, who determines the nature, tendencies, and character of the person. The healer, through a connection with these Orixas, determines what the Orixa wants or requires. The diagnostic ceremonies often involve a ritualized dance and a dissociated state of mind which connects the diagnostician to a parallel world (Moodley 2005). The patient also dances and "gives in" his or her body to the possession of the Orixa who manifests itself in the body of the subject, and this is why this has been called a "religion of the body" (Motta 2005).

Voodoo (or V*odoun*, meaning spirit) is a syncretic belief system mostly of Yoruba origin that informs every aspect of life. In this belief system, the spirits of ancestors are always surrounding those alive. One must be careful not to offend them, by appeasing them constantly because—if offended—they can cause illness and emotional pain. Their appeasement depends on dances and offerings and this may include some sacrifices of small animals (Marshall 2005).

This healing system is also hybridized and there are multiple versions of this system in the various countries where it is embraced (Mitchem 2007). It is known as Macumba in Brazil, in Haiti as Voodoo, in Cuba and the South of the United States as Santeria. In Jamaica, it is called Obeah.

Syncretism Between Aboriginal Religions and Catholic Beliefs in Latin America

When the Spaniards and the Portuguese traveled to America to conquer and colonize it, their main reason was expansion, acquisition of territory, and above all finding precious metals such as gold and silver. However, the kings and queens were also interested in instructing the native population in the Catholic religion and considered the aboriginal polytheism of idols and gods as "demoniacal." The conquerors imposed their religion and attempted to extinguish the old religions, without success. In the religion of many Latin Americans, there is a syncretism of the old religions and Gods, with powers and advocations that are European, but many of the rituals and attributes are a mixture of the old and the new. For instance, the Virgin Mary was assimilated to the mother earth (*Pacha Mama* in the Inca world), *Coatlicue* and *Tonantzin* among the Aztecs, the Moon goddess among the Mayan, i.e., *Ixchel*. In the Catholic religion, the various saints can have "special advocacies" and protective powers, such as Saint Cecilia (patroness of musicians) and Saint Cristopher (patron of drivers). Some saints are particularly effective to find lost objects (San Judas Tadeo) or to acquire a boyfriend (San Antonio de Padua). The "new faith" was complemented with the attributes of the old gods, of the rain, *maiz* (corn), fertility, etc. To this day, people may make special requests to a specific saint to solve a particular disease or problem. The child Jesus has many advocacies and some of these "child Jesus" are particularly asked to heal the conditions that affect children (like the *niño de Atocha* in Mexico). Also in Mexico, there is a tradition of "niños" or "niñas" (boys, girls)—not necessarily *actually* children, but conferred this title due to their innocence and purity of soul, and these living saints can heal a young child or a pregnant woman by imposing their hands and praying, while bathing the person in water. Particularly illustrious is the "Niño Fidencio," who people paid pilgrimage to from distant places only to be cured by him (Zavaleta and Salinas 2009).

The performance of a ritual healing sometimes is necessary as a part of the therapeutic process, which can take place in the presence of the family or neighbors, and at other times has to be private. Religious items often have to be present, as well as certain herbs and objects, such as eggs, perhaps an animal. Alcohol may be necessary to induce the healer to enter into a special state. Often the process involves doing something to the patient, such as touching, cleansing with herbs, blessing, or inviting spirits to leave the body. Also, there may be massage and consumption of a beverage or herbs by the patient. At times, the healer blows smoke from cigarettes, or smoke from incense or of burning "copal" (a resin) to "cleanse" the person or for protection.

Spirit Possession, Purification Rituals, and Traditional Remedies According to Hinduism

A comprehensive description of this very complex belief system is beyond our scope. India is an enormous country with multiple religions and ethnic groups, languages, and religions, the main ones being Hinduism, Islam, and Christian. The clinician dealing with a family "from India" or with Indian background may have to ascertain first which specific beliefs and customs they sustain or practice. Here we only mention a few themes common in the Hindu belief system: these include the importance of rituals, of the calendar, of astrological influences, maintaining purity and cleansing (this is crucial for the infant and the expectant woman) as well as trying to avoid at all costs a possession by spirits.

An expecting woman may consult a healer to deal with anxiety, depression, or other emotional distress. The notion of Karma is important as it implies that people come to the world with a certain destiny or "debt" (or the opportunity for reward) depending on what has happened in previous reincarnations. The present life is just one of those reincarnations. The worldview is spiritual in the sense that the person may have a much longer perspective of life than what is common in cultures where there is no belief in reincarnation. Illnesses and afflictions may be considered as deserved retribution for transgressions in this life or in the past.

The healers may recite “tantras” or have an ability to communicate with spirits and produce relief in the affected person.

Maintaining and Restoring Balance in Chinese Traditional Medicine

The traditional Chinese Medicine emphasized the equilibrium between different elements within the body, for instance, between hot and cold components, yin and yang, and harmony between the different bodily systems (Lam and Lim 2014). Yin refers to damp and dense elements (like blood), while yang refers to the vital energy that moves within the body. *Qi* is the essence of life, which is given to the newborn by his or her parents. It is worth noting that there is a Chinese classification of disorders, including emotional disturbances parallel to the international classification, which has specific conditions that are not diagnosed elsewhere.

Some Traditional Therapeutic Strategies Used During Pregnancy

In most cultures, a pregnancy is considered a delicate state in which the woman and the baby in utero face perils that can be quite serious. In the worst cases, a pregnancy could lead to the demise of the baby or the mother, a fact that until recently was fairly common and still is in many poor countries, i.e., high maternal mortality and perinatal death, as in Haiti and similarly poor countries. Therefore, special precautious had to be taken to prevent complications and to intervene when an alteration or disorder has manifested.

The main conditions to be treated during pregnancy are transvaginal bleeding and the need to prevent a miscarriage. It is also necessary to promote the future mother’s emotional well-being, to strengthen her in preparation for the birth and get a good delivery. Another need arises to deal with the nausea of early pregnancy, with hyperemesis gravidarum and ptyalism. Other common problems are leg cramps and abdominal cramps in general, as well as back ache and pica of pregnancy.

It appears that indeed ginger, a traditional remedy used in many parts of the world for nausea and stomach upset, is beneficial, according to randomized controlled trials (Dante et al. 2013).

In Mexico, *chilca* (*Baccharis latifolia*) is used to accelerate the labor once the woman has started the process. In South Africa, preparations of *Callilepsis laureola* (Impila or Ox eye daisy or Isihlambezo), a wild flower used traditionally by the Zulu, are used during pregnancy as a general tonic to strengthen the woman, and this can lead to toxicity (Varga and Veale 1997).

Baths with marjoram water or “*baños de mejorana*” (*Origanum majorana*) are used to calm the nerves and reduce stress in the expecting person. Also, “*temazcal* baths” (similar to sweat lodges) are used in many countries to help a pregnant woman eliminate negative influences, to diminish her stress, to relax, and to promote a healthy pregnancy in general. These baths often take place in special small “houses” where a hot element (rocks, stones) is poured with water to produce vapors and heat that are thought to be cleansing and curative.

When women from a traditional society have their baby in a hospital milieu, this may seem a very artificial and unusual context. They may be unable to be comforted by traditional remedies or practices, in part because they may not be allowed by the hospital, but also from shame, e.g., fear of bringing religious objects for the moment of delivery.

An important issue for those looking after a family from a different culture is the “language of caring,” or how a person or family might feel welcome and supported in this difficult moment. Often, the demeanor of the hospital unit staff or obstetric ward may appear cold and “too professional,” when the person might need to be touched, soothed, and allowed to express emotions like fear or pain openly. The woman may feel that she is expected to be too restrained and feel uncomfortable in these difficult moments (Small et al. 2002).

Some Traditional Therapeutic Techniques Used in the Postpartum Stage

A perennial concern in many traditional cultures is whether the woman is "impure" or in a "hot state" shortly after the birth of the baby. In many cultures, a recently delivered woman is considered impure, and there are multiple proscriptions as to being with other people or needing to be "confined" (as the postpartum stage used to be called only a century ago in Europe). The postpartum woman could be perceived herself a danger to others due to her "impure state," but more often she is considered particularly at risk due to the enormous effort of the pregnancy and delivery, the bleeding, and the process of giving birth. In some areas of Turkey, a woman is thought to be so vulnerable for 40 days after delivery that there is a saying that "her grave is open for 40 days after the birth." In Turkey, many women fear an "evil woman" called Alkarisi, who can cause puerperal fever and death. The baby (and the new mother) should never be left alone because of the same danger. Traditionally, an onion, a piece of bread, a needle, and a knife were placed under the newly delivered woman's pillow to protect her (Geçkil et al. 2009).

Another important concern is how long the woman should be "at rest" or is vulnerable, and when sexual intercourse can be resumed. In many traditional cultures, there is a period of several weeks, or 40 days in which the woman "should not" have sexual contact. A violation of this proscription might lead to feelings of guilt and marital conflict, if not resentment, if the husband makes demands violating those taboos. In Turkey and many Muslim countries (Geçkil et al. 2009), as well as in China and Latin America, this traditional "quarantine" was used to be enforced carefully, but this is disappearing gradually.

In the postpartum period, remedies are used to promote the production of milk and breastfeeding, and for the woman to recuperate her strength and endure the rigors of caregiving for a small infant. A popular infusion of borage [Borago oficinalis] (borraja in Spanish) is used as a "cleansing agent" and to reduce stress, to improve depression, and also to promote lactation in postpartum women; it has been used in Europe for centuries.

One of the concerns that has gained importance in the last two decades for pregnant women in many industrialized countries is the weight gain associated with it, i.e., the fear of gaining too much weight. Then, after the baby is born, there is often more worry about how to lose the weight. In most traditional societies, this is not a major issue, and in many, being "round" or having a large body is not considered undesirable, but a sign of fertility or beauty. This is of course changing with the increasing globalization of beauty standards.

Issues around weight have been reported in some rural areas of South India. There was a study in which pregnant women were interviewed about their desires regarding the size of the baby at birth. Surprisingly, many women wanted "small babies," under 2.5 kg of body weight, because of a concern with a "puffy baby" not being as healthy and strong (Nichter and Nichter 1983). Also, there appears to be a preference for the women themselves to stay thin and not gain much weight, as this is perceived as not being so suitable to perform hard work around the house or outside.

A traditional herbal remedy that has been used in the United States and Europe is "blue *kohosh*" [*Caulophyllum thalictroides*] which is recommended to help contract the uterus after delivery. If the mother is breastfeeding, it can lead to toxicity in the newborn, as it contains vasoactive glycosides (Elvin-Lewis 2001). Examples like this are important to keep in mind, as in the United States and in many European countries, there is a movement to return to traditional and natural remedies. It should not be assumed that because something is natural, it might not be harmful.

Traditional Therapeutic Techniques During Infancy and Early Childhood

There are a variety of states and conditions for which traditional medicine has been used, and up to the present are employed with infants. Some of them are used to relax the baby, promote good sleep

and a state of calm, particularly in the irritable baby. This is true also for the irritability that mothers associate with teething, and various states of anxiety and fright (Smitherman et al. 2005). Another concern palliated therein is the baby who does not thrive or seems weak or not vigorous enough.

A particular issue for many mothers from traditional cultures is the care of the umbilical area for the newborn. A recent review mostly from studies in industrialized countries did not find an advantage between leaving the cord stump to dry and applying some antibiotic ointment (Zupan et al. 2000). Despite this, the care for the decaying stump, and further, of the umbilicus in the frail abdomen of the infant (prone to umbilical and inguinal herniation) yields many an artisanal and variable care conduct. In various Latin American countries, tradition dictates parents apply some sort of bandage or piece of cloth over the umbilical stump so as to prevent a hernia. In Colombia, Mexico, and other countries, parents used to apply a "coin" under said bandage, despite some risk of infection. Multiple products and substances are used all over the world. In Pakistan, for example, coconut oil, or mustard, is applied, all of which may make the area prone to infection (Fikre et al. 2005). Another product is *surma* (kohl), a black powder with cosmetic uses, made of charcoal (but which, by virtue of its artisanal manufacture may contain variable amounts of lead).

Some interventions follow the principle of "like cures like." In some Southern Afro American communities, for instance, the pain of teething in the baby is used to be soothed by hanging a string of "pearl buttons" around the child's neck (Mitchem 2007). In the Southeast of Turkey, mothers may dress the newborn in a yellow cloth in order to prevent jaundice (Geçkil et al. 2009),

In cultures of China, Latin America, and the Mediterranean region, it is feared that the baby might become wet or be affected by cold drafts. In Latin America, people fear the entrance of "air" (cold air in particular) into the body through the ears or just be exposed to the cold. The "air" may give the baby the chills or make him irritable. "*Serenarse*" (exposure to the evening dew) might result in similar irritability or chills. The baby's head is thought to be particularly vulnerable to the cold-damp dew which makes the baby irritable. Parents refrain from taking the small baby out at night, and, when they must do so, the head should be covered carefully and thoroughly (Zavaleta and Salinas 2009). Interestingly, the baby can be vulnerable to cold air even in a hot climate.

As in most cultures, a baby is perceived as quite vulnerable, conditions like "air" penetrating the child and causing pain or illness. The penetration by some noxious substance may be alleviated by techniques such as "cupping" in which a vacuum is created in a container (like a glass) by burning alcohol and quickly applying the cup on the skin of the child. The resulting negative pressure is believed to "suck the evil influence," or wind, from the child. This is practiced widely in Latin America, Russia, and several Asian countries (Hansen 1997). In moxibustion, a hot object is applied to the skin in a manner similar to acupuncture. However, in this procedure, a small cotton ball or roll of moxa herb (mugwort or *Artemisia vulgaris*) is burned and placed on a specific area of the body of the small child. Traditional Chinese medicine would recommended this for behaviors as broad as enuresis and temper tantrums. The theory is that a "yang therapy" (heat) counterbalances a "cold site" inside the baby or young child which is causing the problem. In some Arab countries, "*maqua*s" are small burns also used with curative purposes. In Turkey, salting of the skin used to be considered a healthy practice to protect the skin of the baby (Yercen et al. 1993; Peker et al. 2010). Turkish tradition dictated that in order to prevent jaundice, some "small cuts" could be made on the newborn's forehead, behind the ears, and the wrists, which should not be confused with child abuse (Oziazicioglu and Polat 2004).

A particular issue for infants is the use of enemas which in many healing traditions are prescribed to "cleanse" the body and to eliminate magical influences which are thought negative. If they are applied frequently, or if the substance used for the enema is irritant, it can have terrible consequences for the baby (Kale 1995). The

same can be said about emetics and herbal drinks, some of them are innocuous but some could be dangerous or toxic, causing poisoning in the baby. The clinician should be careful to endorse them, except on a case-by-case basis after consulting with a well-informed physician or pediatrician. A major obstacle, however, is that some healers keep the content of their remedies secret. Parents may need to be advised of some dangers involved.

A particular ingredient called pyrrolizidine has been identified in several herbal remedies commonly given to babies in some countries in Sub-Saharan Africa. If administered at higher doses by desperate parents, or more frequently than prescribed, it can lead to lung and liver toxicity, which can be lethal (Conradie et al. 2005).

Star Anise (*Ilicium verum*) from China is considered safe for young children, and is a popular infusion given for colic across cultures. However, if contaminated with Japanese star anise (*Illicium anisatum*), it can cause neural toxicity (Ize-Ludlow et al. 2004).

Another area of potential concern is the condition called "*caida de mollera*" (sunken fontanelle) which is diagnosed in many cultures, and in the Latin American groups it is a complex condition that could involve dehydration, but also "negative influences" or even witchcraft. Beyond medical considerations, a potential problem is in-and-of-itself the "cure," which may include turning the baby upside down by a *curandero* holding the baby by the feet, thus hoping to reverse the sinking of the fontanelle. The maneuver has many risks, even the potential of causing a shaken baby syndrome-like presentation (Hansen 1997).

Issues in Psychotherapy and Other Mental Health Interventions

There are a number of questions when approaching a family from any background. One of them is the awareness of the specific culture in question. The clinician does not have to be an expert on the traditions and customs of the thousands of possibilities, but can be open to learn about customs and traditions from each specific family. The most important issue is a receptive approach toward learning and not empirically assuming to already know everything because a family belongs to a certain tribe, culture, country, or religion. It is useful to inquire and listen to the response, to try to understand the worldview and values of the specific family. With families from traditional cultures, some issues to take into account may be commonly held, such as an orientation to the present, rather than to the past. The cautiousness with which a family may approach a mental health professional from a different background, as well as the hopes and expectations they may have for their child. In many traditional societies, there is an intense respect for the individuality and preferences even of a young child and parents may accept the child as "the way he is" or "the way she is," which is different from the more authoritative view that the parents are always in charge, they "mold" the child, and have the last word on every decision affecting their son or daughter.

Some clinicians emphasize the importance of fostering resilience in working with stressed populations (Grandbois and Sanders 2009). In the case of Native American families, the concept of "oneness with the universe" and the feeling of interconnectedness seem valuable to help them see their problems in perspective and to accept help from others.

An important value for many families from traditional cultures, which affects their view of "disturbance," is the notion of harmony with nature, and the view of problems not in a categorical and fragmented way which is common in the Westernized mind (genes, microbes, toxins, diet, environment as *the* source of illness), but more from a holistic perspective of nature of which humans, like a child, is only a small part. The therapist may have to be prepared to work in collaboration with a traditional healer.

An additional point regarding psychotherapy is the issue of linear thinking, or "cause and effect" thought to attribute a problem or symptom to one cause. A consequence of a more "relational thinking" is that more "time-limited" or "goal-oriented" therapies may not be as suitable to a culture in which people do not think so much

of calendar, time tables, and schedules, and in which the thinking is more complex as to the nature of problems, multidetermined and multicausal, interrelated to other problems and circumstances, and the very objectified methods may not be as applicable.

A very direct style of questioning and addressing topics may be considered as intrusive or rude, for instance, in working with Native American families, like in many other traditional cultures. A more indirect, "meandering" and oblique style of addressing issues may be considered more friendly and trustworthy. The style of interacting may include not shaking hands, not making persistent eye contact, and even a lower volume of speech may be useful (Weaver 1999). Direct eye contact traditionally is considered rude among the Dine, many other tribes, and in many Asian and African cultures. Silence on the part of the patient may be valued as an opportunity to reflect and collect one's thoughts before speaking, which may be uncomfortable to the Westernized clinician.

The therapist working with a young family may want to include family members that are outside the "nuclear family" and which have a real impact on the life of young parents and small children. This may include grandparents, aunts, uncles, and other relatives that the family considers important.

Particularly, when one works with families who live in a segregated area or are not in as much interaction with "modern" services, several things might be taken into account. Punctuality is not as important to the caregivers as it might be in the mind of the therapist. If a person on his/her way to an appointment happens to encounter someone else who is known, being sensitive to that person and stopping to engage in interaction with the acquaintance would take precedence over punctuality.

If a young child does not want to attend the appointment or expresses not wanting to go, the parent might not necessarily force the child to attend. "Talking about one's problems" may be rather foreign to the child and the parents. In many traditional groups, spoken words are not used as much to describe inner states, emotions, fantasies, or feelings. These are often implied or read "in the face" or "in the actions" of the person implied, rather than stated openly. The clinician may need to be willing to accept very brief statements that are not rich narratives of events or internal states.

Activities performed together, such as drawings or others, may be more conducive to help the child/parent feel at ease, rather than sitting face to face and expecting the parents to bare their soul. This would be very different with a more "modern" family that is used to the conventions that are common in Westernized families.

The mental health clinician dealing with families in the perinatal stage and with young children is wise to keep an "open mind" regarding the family's involvement with traditional remedies, shamans, or healers. Many families might feel embarrassed to discuss this topic with the clinician for fear of being considered ignorant, or ridiculous for their reliance on traditional and "superstitious" strategies. The clinician might reassure the family, indicating that many families use the wisdom of their elders or their culture to deal with problems and one would like to know about them in order to take into account what one might recommend, including the opinion or diagnosis of the healer, relative, or elder, as well as their recommendations.

In many highly industrialized and technologically advanced countries, like the United States, the medical profession has become divided into specialties and subspecialties. This has advantages and negative effects. On the one hand, the super-specialist knows much about a particular area of dysfunction or illness, organ system, or actual organ, which allows much experience with that condition. However, such physician may limit himself only to "certain diseases" and focus only on those. If the patient has other complaints, or emotional difficulties even associated with the original condition, the physician would refer to another specialist. This leads to a high degree of fragmentation. Many physicians follow "algorithms" which are decision trees that dictate their practice in a "technical way," in which the "average patient" is the starting point. The relationships, the conflicts, the specific circumstances in

the family or work environment, let alone the cultural beliefs, fears, and traditions, are often not taken into account by very busy clinicians, who only focus on "one disease" or one system. Kale (1995), examining the traditional medical practices in South Africa, particularly the healers, suggests that modern physicians may have something to learn from shamans and healers. In the healer's practice, it is essential to listen to the patient and to take into account his or her circumstances in great detail, and the patient has to have enough time to express concerns and symptoms, in his own words and with the undivided attention of the healer. The patient is seen "as a whole" not as having separate mind and body and is seen as a member of a specific family and social group. This may be a part of the healing strategy and of the patient's response and satisfaction with the care received. In many countries, traditional healers have an important place in the fabric of society (as in China, many African countries, and Latin American ones). Incidentally, in China, traditional medicine continues to be very popular, accounting for 40% of all health care requests (WHO 2002–2005). They are invited to be incorporated into the national health system, to register and to be assisted in their further education and training. In Cuba, traditional and natural remedies knowledge is part of the formal training of physicians, most of whom practice both the modern and the traditional therapeutics (Appelbaum et al. 2006).

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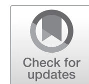

22 Future Directions in Research and Practice

Andrés Jiménez-Gómez
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Future Trends in Research and Practice

There are multiple levels in which the approach to children and families could improve from the clinical point of view. This would involve several levels of intervention; the main areas in the clinical setting would be:

(a) Clinical practice and care of families from a transcultural framework, in addition to the genetic, molecular, organic, individual, and psychosocial levels of understanding a child and/or a family
(b) Clinical research on the issues and problems presented, therapeutic strategies which are acceptable for a given population, and patterns of presentation of distress. Also, studying etiological theories and therapeutic beliefs of different populations.
(c) Education. This area involves an "in-depth" exposure to the emotions and reactions of people who are "different from us" or "not like us," and who act differently, come from another area of the world, etc. This involves helping clinicians understand the struggles, strengths, and problems faced by individuals and families in the perinatal and early childhood period when they come from a different background from ours.

Mental Health Interventions

As in other areas of medicine, there are several levels of "prevention or intervention" with populations and individuals who may face emotional and behavioral problems in this stage of life, be it the parents-to-be or the young child, or the interaction between parents and children.

(a) Primary prevention
(b) Identification of at-risk children and families
(c) Developing skills for alleviation of distress for children and families.

Primary prevention involves the promotion of mental health. This would involve an understanding of what "other people think," how they see the world, and what are their theories of distress. It also deals with promoting a state of emotional well-being in expecting couples and young children. The program described by Lecannelier in this book is an attempt in this regard, working to

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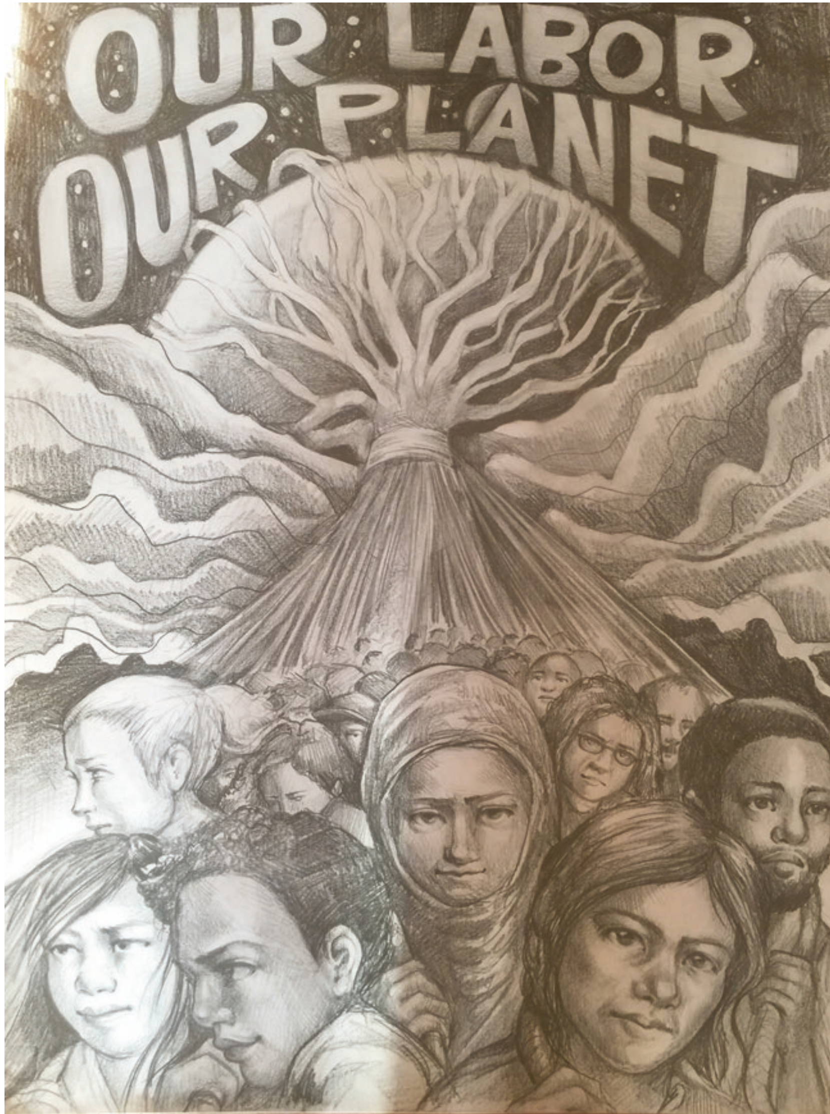

Fig. 22.1 Multiculturalism. (Original artwork by Ana-Marcela Maldonado-Morales)

promote the public's awareness of the issues of parental sensitivity, empathic child rearing, and promoting the development of a secure attachment in children. It also involves working with populations at particular risk.

Primary prevention is often seen as a cognitive intervention, i.e., providing information or mere education. However, there has to be an emotional component to this education, i.e., an emotional involvement and the promotion of empathy and identification "with the other," rather than just developing catalogues of "what other people do" or of "unusual practices."

The secondary and tertiary levels of intervention have been described in the various chapters of this book.

The leadership of an institution or facility needs to be supportive and help the staff to accept or welcome others. This could include special populations of any kind, not only different in their ethnicity or natural original, but other parameters.

Interpreters should be selected and trained carefully, not only due to their language skills, but in their ability to illuminate the health care staff about the meaning of certain rituals, clothes, colors, gestures, responses, preferences, and taboos in various cultural groups. They should be professionals bound by the same rules of confidentiality as other health care staff.

The public in many countries, and multiple professionals even in a "globalized" environment adhere to the belief that there should be only one national language, and that immigrants "should" speak that language and adopt the values as the people in the host country. This prescribes that everybody should embrace that language and preferably abandon their previous tongue. This usually accompanies the opinion that immigrants should assimilate and try to "be more like us." Many immigrants and thinkers respond, "we would not be here, if you had not invaded or colonized our country," or "there is no indication that the colonizers attempted to assimilate to the language and customs of the people they conquered." This is a difficult issue, but a simplistic solution is not realistic and impossible in any case. Immigrants vary enormously in their interest in learning new ways of communicating, relating, and changing, and preferences. Some will embrace the new culture with open arms while others will not do that, based on multiple factors. As we have seen, many people would prefer not "abandoning their culture" and decide to be bicultural or multicultural. Trying to assimilate is also difficult. A young man who originally was born in Hungary was taken by his parents to Croatia where he spent about 15 years of his life. Then he returned to Hungary for higher education. Ten years later, he reports that when he is in Hungary, some people think that he is "too Croatian" and in Croatia that he is "too Hungarian." Similar experiences are reported by many people who have spent long periods of time in different countries or cultures and are no longer "pure" in being from just one background.

If a facility or organization embraces the idea of "purity" of the language or culture, or prejudiced values, it may be unsuitable to meet the needs of a diverse population.

Family and group psychotherapeutic approaches might be more acceptable for some immigrant populations rather than only the purely individual clinical interventions. This is so because many people may see themselves as intimately connected (and being interdependent) with their mother, father, and grandparents; even though in a modern or Westernized milieu, the adult is assumed to be "their own person" with total agency and autonomy, this may not be the view of many immigrants.

Group interventions could provide connections with other people going through "the same" problems in the new environment, and help create supportive networks of individuals or families that might help new immigrants by pointing out common reactions, strategies that were used which were helpful in the new country, and common concerns and issues that were faced by the older immigrants. This would diminish the feelings of isolation, and it might help them to deal with the mourning of the country of origin and its culture, its foods, traditional practices, etc.

Research needs

1. One need is to explore, mostly through in-depth interviews and focus groups, different aspects of the cultural dimension in various clinical settings. The candidate questions to be explored further would be:
   - How welcome do individuals and families feel in various clinical settings?
   - Do personnel seem to value the presence of an individual or family in the specific clinical setting? Were differences appreciated or valued, or merely "tolerated" or dealt with as "a problem?"
   - Do individuals and families feel that the staff attempts to understand them and respects their beliefs and way of life?
   - Do facilities promote messages that incorporate acceptance of "the other" in terms of language, celebrations, and awareness of what is important for people from a different cultural background?
   - Does a clinic or facility have staff with some degree of interest or expertise in creating bridges to understand and help peo-

ple from a different background, culture, or country? Does the staff attempt to understand their values and taboos?

- What is involved in "acculturation?" Should assimilation and becoming a "melting pot" be recommended for all families? What about multiculturalism vs. having a "national culture" and national identity?
- Are there strengths, values, and care practices that could be valuable for the people in the host country as they deal with immigrants and refugees? Can groups in the host country accept new ways of thinking, different ways of relating, and of understanding the world? What are the strengths of immigrant families that are associated with better health outcomes and less frequency of emotional and behavioral difficulties?
- Are there childcare practices from which one could learn, or which are associated with less problems? For example, the degree of parental involvement, physical contact, or the importance of the extended family.
- What role do families play in promoting or undermining individual resilience? Are there specific aspects of family relationships that foster well-being and others that worsen mental health?
- What are the issues involved in the migration experience from one country to another, or internally in one country? What is the effect on current and next generations? What is the effect of trauma and losses on the immigrants and on their parenting strategies and what do they transmit to their children? How does this affect the emotions and behaviors of the children and grandchildren?
- How does one measure or evaluate the degree of acculturation of an individual or family? This could include the language or languages spoken in the house, within the family and "outside." What holidays do they celebrate, and have the food habits and physical activity changed with assimilation? How does acculturation affect the spheres of intimacy, family bonds, family obligations, parental beliefs?
- There is a multitude of acculturation scales, developed in countries like the United States, Australia, Canada, and others. They measure the degree to which people have adopted the new ways of life, holidays, friendships with natives of that country, and which language is spoken, or in which language the person prefers to think, read, or use mass media of communication. Most of them rely considerably on language preferences and relationships. The general tendency has been to measure the degree of assimilation on one end of the spectrum or "marginalization" on the other. In marginalization, the person has "given up" adopting much about the host country, including the dominant language and lives in a sort of subculture. The scales have been described for Vietnamese immigrants, Chinese, South East Asians (Anderson et al. 1993), Hispanics (Marin and Gemba 1996), Mexican-Americans (Cuellar et al. 1980), Arabs, Greeks, etc. Also, there are some general scales, for instance, for adolescents (Unger et al. 2002). Although most scales emphasize language and relationships with friends, there are some that are based on dietary preferences, like one for Chinese Americans (Satia et al. 2001). Most scales have been developed for adults or adolescents, but there are some for children, for example, one for Mexican-American children (Franco 1983).
- One way to study the process of assimilation is the tendency of parents to name their children adopting the local-host country names, as opposed to the traditional ones (Abramitzky et al. 2016). One assumption is the parents who start using English names in the United States, or German names in Germany, Austria, Switzerland, etc. are more likely to adopt the local costumes, speak the local language, and leave behind some or most of their traditions. Latino families may decide to call their child "Miguel" or "Michael,"

and this is apparently associated with the tendency to assimilate. Parents may worry that giving a "too ethnic" name may lower the chances of their child in the future to obtain employment or enter some social or professional circles. This may happen with "African-sounding" names, for example. This tendency to discriminate based on assumptions from names has been documented historically (Goldstein and Stecklov 2016). Also, there is evidence that "foreigners" in the United States who as adults change their name to more "local sounding" name, for instance an English first and last name, improve their professional outlook by that mere fact (Carneiro et al. 2015)

– In some cultures, people have "double names," like among some Jewish and Chinese groups. Boys may have a "Hebrew" name for religious functions and an English name. Many Chinese adopt informally an "English sounding"; first name that remote resembles the real "Chinese name." Indeed, in research on segregation discrimination, a measure called the "foreignness index" (in the United States) of F-index has been used.
– Another strategy to acculturate or assimilate is "intermarriage," or the marriage between spouses of different background. If an Afro American man marries a Caucasian woman, multiple accommodations have to be made for cultural practices and naming the infant. This intermarriage may contribute to eliminate the clear distinctions people make between ethnic groups.

Unresolved Problems

We have deliberately not mentioned so far very difficult problems of human rights and cultural relativism. The question is this, just because something is traditional, firmly believed, valued, should it be condoned? This might apply to practices that most people find objectionable such as infibulation (the surgical closing of the vaginal opening performed in girls in some cultures), clitoridectomy (ablation of the clitoris to diminish pleasure during sexual activity), child labor (which is performed widely for reasons of poverty, and a tradition of children not going to school in order to help their parents in the farm, or somewhere else). Another would be the forced marriage of girls to some person they do not know because it is convenient for her family. There is no easy solution or proposal to address these problems. One approach is the United Nations Declaration of the Rights of Children (UNICEF 1989). The declaration does not mean that the signatory countries and all those who have ratified it are going to adhere to it. The declaration includes the freedom of children from being forced to work, from being abused, from being sold, etc.

The question of the surgical procedures is immediately extended to issues like the circumcision of newborns. This is an operation widely performed in the Western world, for instance, in the United States mostly upon medical recommendations. However, it is ritually performed among Jewish and Muslim families. Most people outside certain cultures would condemn infibulation and clitoridectomy, but not necessarily circumcision. These questions are not easy to address and require that people increase their awareness of the problem, and perhaps "from inside" force changes that might make children have a better quality of life. Foot binding has disappeared in China, but it was a widely practiced procedure for "esthetic reasons" despite the major health consequences on women's lives (Mackie 1996). Despite the fact that the practice had lasted about a thousand years, foot-binding changed very quickly in one generation with the revolution, but other practices that we might find objectionable persist.

Infibulation is a particular problem in the Western world when an immigrant woman, from Somalia or Sudan, has undergone infibulation and is about to have a baby. The practice continues to be embraced in several countries, e.g., Nigeria, Somalia, Sudan, and others (Chibber et al. 2011).

The baby can be born trans-vaginally with surgical assistance (Rouzi et al. 2001). But a further problem arises when her husband or family request that the vulvar area be restored to its previous state. This presents a major ethical dilemma for the obstetrician or surgeon. If the request is not met, what would be the reaction of the husband to his wife? Can ethically an operation like that be performed because he wants it? Even if the woman were to request it, is it because she desires or because the quality of her life would be affected if she does not have the surgery?

A similar issue is the quality of life of women. What are women's rights? Just because a woman is married, is it her duty to "satisfy her husband" whenever he wants? Should she be subservient to him in other areas or should the marriage be more "democratic"? Women are oppressed all over the world, more in some societies than in others, but how can change be generated? It seems that it cannot be imposed from outside, but that the forces within a country or culture should struggle for those changes, perhaps with the assistance of international organizations.

Global Health Participation

A relatively recent development, interest in global health participation, has received substantial attention within the past decade among academic training programs across medical specialties, particularly in multiple aspects of maternal and child health which include psychiatric and behavioral care of the infant and mother (WHO 2017; Whiteford et al. 2015). Mental disorders have consistently been projected to become leading causes of disability across the planet in the coming years, with an underestimated total prevalence; it has become natural to pair need with interest in these endeavors seeking to palliate said deficiencies.

Notwithstanding, whereas the concept of providing medical care in foreign settings may have certain straightforward elements (i.e., we are all susceptible to infection, physical trauma, stroke, etc.; and the treatments may look much the same, with limited regional nuances), the delivery of mental and developmental health within different cultures is much distinct than the delivery to these same individuals within one's own culture (considering factors such as assimilation, westernization, among others). Bona fide attempts to bring these services to regions in much need may in fact fail to deliver at the degree intended (Citrin et al. 2017): at best, perhaps, provide deficient, isolated, and non-sustainable rotations essentially at the whim of the participating professionals, and at best, even place undue burden on the local health systems, or alienate the professionals that entirely misunderstand the cultures in which they participate. One such major example has been described—even in non-clinical assistance—as *toxic aid* (Edwards 2014). In this model, groups of participants arrive and provide services perceived to be helpful; however, they are unadjusted to the local setting and needs, unduly tax current providers and staff, negate the truly feasible management strategies (adjusted to local socioeconomic circumstances), and instead become unfairly critical of the deficiencies. Upon completion of their venture, these groups depart leaving behind no groundwork for sustainable endeavors, and often—lacking insight—tout their experiences in their home country, prompting pity for the locals left behind and seeking (consciously or unconsciously) recognition and reward from their peers at home. Despite the malignant consequences of such presence, host institutions or communities may find themselves in a position in which manifesting discontent regarding these visitors before their home institutions could appear to risk compromising other economic or logistic benefits, hence the undue burden is absorbed silently.

In seeking to participate in global health endeavors in any capacity, but most assertively within maternal and child mental health, health care providers need to observe a number of principles, and recognize a number of potential pitfalls they may inadvertently confront.

Local Needs Assessment

A major pitfall—beyond personal ignorance an individual may have preceding international/global health ventures—is a broader scale misunderstanding of the needs of the local communities. Demonstrating cultural competency and engagement demands an understanding of the local and regional disease epidemiology—and, of course, the cultural perceptions of these ailments, as described in detail in previous chapters.

A broad interest in detailing and categorizing global health epidemiology across disciplines has emerged over the past 25 years, namely triggered by the initial declaration of millennium development goals (United Nations 2000. http://www.un.org/millenniumgoals/), subsequently reiterated and repurposed as the sustainable development goals (United Nations 2015, https://sustainabledevelopment.un.org/). In finer detail, within clinical sciences, several multi-stakeholder groups have sought to provide extensive epidemiologic contributions to centralized databases yielding massive macro and microscopic data and data analyses regarding global disease epidemiology. The most notable such example has been the periodic series "Global Burden of Disease" study (The Lancet, 2018), housed in the Institute for Health Metrics and Evaluation (IHME 2018, http://www.healthdata.org/). Specifically, the analysis of this data has led to fine-tuning not only the disease burden at a specialty and subspecialty level (in mental health, with many published examples such as Vigo et al. 2016; Barane and Falissard 2018; Whiteford et al. 2013), but the regional clinical capacity to confront such burden.

While this data provides insight regarding a "macroeconomic" view of the local situation for visitors, it becomes an unavoidable responsibility for visitors to establish a further specified understanding of needs—a needs assessment—preceding travel that identifies where the aforementioned burden and capacity display a mismatch that visitors can help palliate. At local/institutional levels, this is the nature of Quality Improvement (QI) projects (Katakam and Suresh 2017), which needn't have an extensive investigational protocol or research-level data analysis seeking academic publication; the mere bidirectional evaluation by stakeholders to review their data and establish objectives and "ground rules" preceding travel suffices in fulfilling this need (Crump and Sugarman 2010). The responsibility and burden rests, however, mainly on the visitor.

Cultural Understanding, Competency, and Humility

A major element of concern in global health care delivery—and the central theme of this entire textbook—is the true and thorough understanding and respectful adaptation to the host's culture and social nuances.

What defines cultural understanding can be readily inferred in both general concepts as in culture-specific domains throughout prior chapters; however, how are cultural humility—and the desired outcome, cultural competence—defined?

It is important to note that while these terms have had a substantial increase in their use at an academic level, a unified definition has not been proposed suggesting that, while a somewhat confluent understanding of what these terms represent may exist, the overall idea remains elusive and, perhaps even, interpreted in many different ways by different individuals and communities/hosts. From a European perspective, Mews et al. (2018) have recently provided a series of operative definitions for competency, or the elements therein: an understanding of culture from a sociologic and anthropologic perspective vis-à-vis the clinician's own socialization and culture. The awareness of such, linked with a constant self-reflection leads to constant desired adaptation in care delivery responsive to a wealth of determinants, spanning background, migrations, beliefs, hierarchies, and medical literacy among others.

The most salient feature noted within this definition and others is the intimate relationship between self-reflection and humility as drivers of successful cultural competency. Humility is an inherent driver of curiosity: cultural humility drives the search for overlapping, complementing, and divergent aspects of one's own and other cultures. It is this curiosity that in turn leads to enriched knowledge and reflection.

Culture Shock and Reverse Culture Shock

An important set of elements to international cross-cultural experiences is the concepts of culture shock and reverse culture shock. The former describes the experience of confronting a clinical practice setting wherein the deficiencies or mere differences of practice, and the displacement of all familiar traits and settings, place emotional and physical stress upon the visitor. It typically follows an initial "honeymoon" wherein the individual enjoys and participates in the novel setting. The latter—also called reentry—describes the re-adaptation and unanticipated emotional and physical stress incurred in visitors who—upon returning to highly privileged settings that are their very homes—struggle to adapt and question the mission, worth, and value of the participation in the society from which they yield. Both phenomena have been described and studied for decades (Oberg 1960; Gaw 2000). Both phenomena—when successfully dealt with—should entail eventual adjustment and acceptance within the setting (Guru et al. 2012). It becomes imperative for participants to anticipate both of these phenomena and to identify appropriate assistance at both points of their endeavor. To this end, clinical training programs across high income settings have provisioned serial "check-ins" during the visitor's experience as it occurs, as well as post-return "debrief" sessions seeking to identify these consequences and treat as needed (Khan et al. 2017; Butteris et al. 2014).

Adaptation to the Local Medium

Beyond the concept of culture as the set of societal values of the patient populations, visitors must understand the set of logistic and institutional/regional culture traits that govern the host sites. Frequently encased in a mismatch between his or her own perceived abilities and expectations (especially when coming from resource-intensive communities wherein capacity limits often appear nonexistent) with real and feasible outcomes, visitors present a challenge to hosts from the very "orientation," i.e., the onset of their participation in local delivery of mental health services. It is essential that roles are clearly established, defined, and assimilated even prior to the initial arrival at a host site. This is an important step to adjust expectations of the role of the visitor not only for visitors themselves, but also for the hosts. The very presence of these individuals may appear to hosts in extremely burdened and stretched services as a "relief" and a "relay," leading these to place an irresponsible burden on the visitor who may not have the clinical preparation for the job, let alone the cultural understanding to place these clinical skills to good use (Crump and Sugarman 2008). Reciprocally, an oblivious and disorganized visitor—regardless of cultural understanding of the community—may require an extensive orientation to understand their clinical role within the host institution/community. This in itself may require drawing busy and much needed local clinicians from their duties, to satisfy otherwise clerical and unrewarding tasks in "orienting" the visitor to the environment.

Among clinical training programs including those in mental health services, pre-departure orientation has become a targeted and desired element of global health participation (Crump and Sugarman 2008; St. Clair et al. 2017). The content of these courses or "boot camps" tends to vary in adaptation to social, cultural, and logistic factors (besides, of course, specialties). However, the overall intent is to maximize the swift adaptation to the local medium and minimize the aforementioned culturally traumatic experiences.

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